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ABSTRACT

This guide contains all of the information, support and tools teachers will need to implement "Talking about Mental Illness" in their classroom--an awareness program that has been proven to bring about positive change in students' knowledge and attitudes about mental illness. The program supports teachers in four essential ways: it outlines the links between the program and the new Ontario Secondary School Curriculum Guidelines; it provides teachers with practical, ready-to-use information on mental illness; it offers teachers and students an opportunity to meet and interact with people who have experienced mental illness first-hand; and it provides links to community resources and support for further information and professional help. The information contained in this guide includes: practical ideas and suggestions for secondary school teachers teaching about mental illness; curriculum guidelines for a variety of courses showing how the program fits curriculum requirements; ready-to-use overheads and activities that address issues such as the impact of stigma on the lives of people with mental illness, and types, causes and treatments of mental illness; evaluation tools to help teachers measure the program's impact on students' knowledge and attitudes; and suggestions for resources and supports for teachers. Eight appendixes include curriculum guidelines, mental health-related Web sites, resources for youth, toll-free phone lines, Ontario mental health organizations, suggested audiovisual resources, additional programs and resources, and overheads and handouts. (GCP)

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TEACHER'S RESOURCE

Talking about mental illness

A guide for developing an awareness program for youth

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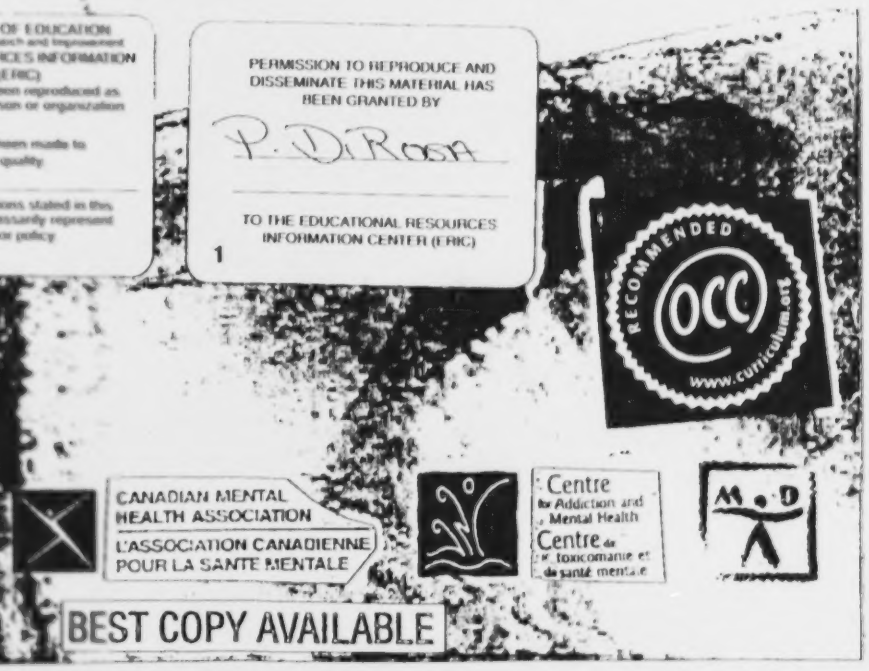

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Teacher's Resource

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PREFACE

This guide contains all of the information, support and tools teachers will need to implement "Talking about Mental Illness" in their classroom — an awareness program that has been proven to bring about positive change in students' knowledge and attitudes about mental illness.

The program supports teachers in four essential ways: 1) it outlines the links between the program and the new Ontario Secondary School Curriculum Guidelines; 2) it provides teachers with practical, ready-to-use information on mental illness; 3) it offers teachers and students an opportunity to meet and interact with people who have experienced mental illness first-hand; and 4) it provides links to community resources and support for further information and professional help.

WHAT'S INSIDE?

The information contained in this guide includes:

- practical ideas and suggestions for secondary school teachers teaching about mental illness
- curriculum guidelines for a variety of courses showing how the program fits curriculum requirements
- ready-to-use overheads and activities that address issues such as the impact of stigma on the lives of people with mental illness, and types, causes and treatments of mental illness
- evaluation tools to help teachers measure the program's impact on students' knowledge and attitudes
- suggestions for resources and supports for teachers.

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INTRODUCTION

BACKGROUND TO THE PROGRAM

Stigma continues to be a huge problem for people living with mental illness. It undermines a person's sense of self, relationships, well-being and prospects for recovery. Communities make a difference through education and awareness programs. ***This guide includes ideas and tools that can help teachers increase awareness about mental illness and the stigma that surrounds it.***

The guide is based on learnings from Beyond the Cuckoo's Nest, an awareness program for youth, aged 15 and older. The program was started in Toronto in 1988 by nurse case managers at the former Clarke Institute of Psychiatry (one of the founding partners of the Centre for Addiction and Mental Health). It was developed in response to the community's expressed need for information on mental illness. The original program consisted of a two-hour presentation designed to give secondary school students facts about mental illness and create opportunities for them to interact with people who have first-hand experience with mental illness.

People who have experienced mental illness, family members of people with mental illness and health professionals deliver the program. Presenters talk about their experiences — what it was like when the symptoms of mental illness first developed, where they went for help and how they are currently managing. Students benefit from a unique learning experience, particularly the opportunity to meet and talk to individuals who have been affected by mental illness. After attending the program, students often say, "people with mental illness are just like everyone else."

The program's success, and the desire to share the benefits of Beyond the Cuckoo's Nest with people in communities throughout Ontario, led to the development of a second project in 1998. This project involved three partners: the Centre for Addiction and Mental Health, the Canadian Mental Health Association (Ontario Division) and the Mood Disorders Association of Ontario. Each partner shares the goals of increasing knowledge and understanding of mental illness and eliminating stigma.

The project took place in three communities: Hamilton, North Bay and Kingston. Its goals were to develop and deliver awareness presentations in each community, and to develop resource materials that would assist other communities across the province in delivering their own awareness programs. Although the communities used Beyond the Cuckoo's Nest as their template, they changed the program to reflect local needs and resources.

In focus groups and evaluations that were conducted with student and teacher participants who took part in the program, both groups recommended certain changes to improve the program. They suggested that the program should:
(1) include a classroom component to cover preparatory and follow-up activities to better equip students for the presentation
(2) devote the presentation entirely to people's stories.
These changes are reflected in this guide.

In keeping with the participants' recommendations, the program described in this guide prepares students and provides follow-up to the presentation, which consists entirely of people's accounts of their experiences with mental illness. The preparation enables students to get the most out of the presentation and the follow-up addresses concerns and issues that were raised. Section 2 further discusses the four flexible component modules around which the program is organized.

OVERVIEW OF THE GUIDE

Who is this guide for?

This guide is intended for teachers in secondary schools across Ontario, particularly those who teach courses in which mental health and mental illness are highlighted. However, it is relevant for any teacher who is interested in exploring these topic areas in other courses.

What's in the guide?

Section 1 discusses the stigma surrounding mental illness and examines the rationale for the awareness program. It also provides a brief outline of the program's goals and objectives.

Section 2 provides an overview of the four components of the program, which include:

- an introduction to the concept of stigma
- an overview of major mental illnesses, their causes and treatment
- the presentation
- follow-up activities.

These components address ways of preparing for, carrying out and following up on the presentation in order to maximize students' learning. This section provides a rationale for each component, as well as a description, instructions and necessary tools to carry out the suggested educational activities.

Section 3 discusses the program's evaluation, and provides helpful suggestions and tools that you can use to evaluate the program in your school.

In Section 4, the Appendices, you'll find a variety of useful resources, including master copies of all overheads and handouts, excerpts from the Ontario curriculum guidelines for relevant secondary school courses and a list of suggestions for further information, including articles, Web sites, organizations and audiovisual resources that deal with mental illness and stigma.

The accompanying *Community Guide* outlines the process for building local coalitions and the steps involved in planning and organizing awareness programs.

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SECTION 1: INFORMATION ABOUT THE PROGRAM

RATIONALE FOR THE PROGRAM

What is stigma?

The term stigma refers to any attribute, trait or disorder that causes a person to be labelled as unacceptably different from "normal" people. Individuals with mental illnesses — such as schizophrenia, bipolar disorder and depression — have a double burden. Not only must they cope with disabling disorders, but they must also contend with people's negative attitudes toward those disorders.

Kay Redfield Jamison said, in an article discussing stigma, "It would be hard to overstate the degree of stigmatization faced by those who have mental illness: it is pervasive in society, rampant in the media, and common within the medical profession" (Jamison, 1998, p. 1053).

Stereotypes of people with mental illness are just as inaccurate and dehumanizing as stereotypes of women, racial minorities, people with physical and developmental disabilities, and people from other diverse groups. While we still have a long way to go, ongoing efforts to combat stigma and discrimination have resulted in the questioning of negative

stereotypes and have led to positive change in public perception of such groups, including our perceptions of people with mental illness.

Why do we stigmatize mental illness?

Most people learn what they know about mental illness from the media. We are exposed daily to radio, television and newspaper accounts that present people with mental illness as violent, criminal, dangerous, comical, incompetent and fundamentally different from other people. These inaccurate images perpetuate unfavourable stereotypes, which can lead to the rejection, marginalization and neglect of people with mental illnesses.

Commonly held misconceptions of people with mental illness include the following:

- People with mental illness are all potentially violent and dangerous.
- People with mental illness are somehow responsible for their condition.
- People with mental illness have nothing positive to contribute.

"The program made me realize that people with mental illness are just normal people, and there is no need to be afraid."

(Student who participated in the program)

One of the most common misconceptions is that people with mental illness are violent. Sensationalized reporting by the media bears much of the blame, as do television and movie portrayals of "crazed axe murderers." The stereotype of the violent mental patient causes public fear and avoidance of people with mental illness. According to the Ontario Division of the Canadian Mental Health Association, people with mental illness are no more dangerous than people who do not experience mental illness (2000). In fact, people with diseases such as schizophrenia are far more likely to be violent toward themselves than toward others. Forty to 50 per cent of people with schizophrenia attempt suicide; 10 per cent succeed.

Someone diagnosed with a mental illness is perceived very differently from someone hospitalized for a physical condition such as heart disease or a broken leg. Many people don't understand that schizophrenia is an illness. They may think: "Can't you just discipline your thinking?" The Web site www.openthedoors.com, which raises awareness about stigma associated with schizophrenia, responds: "But you can't discipline a virus, cancer cells or a broken leg."

There is a lingering perception that it's a person's own fault if he or she suffers from mental illness. Mental illness has been wrongfully characterized as a weakness or character flaw, as something people bring upon themselves or their children and as something that people use to

get attention. Yet, mental illness occurs all over the world, in all races, in all cultures and in all social classes.

Another common myth about people with mental illness is that they cannot live independently, let alone make significant contributions to the community. Throughout history, however, people with serious mental health problems have contributed enormously to our societies. A quick glance at the list "Famous People with Mental Illness" on page 33 notes just some of the people with mental illness who have been leaders and visionaries and have enriched and expanded our knowledge and understanding in every arena — politics, culture, academics, business, athletics, arts and science.

"Young people need to know that mental illness doesn't only affect those they might expect. Mental illness affects everyone, and it's more than likely that, at some point in their lives, they're going to have to deal with it either personally or with a family member or a friend."

(A participant in the program)

How does stigma affect people's lives?

There are many negative stereotypes about mental illness, including those just mentioned. These misconceptions have a direct impact on attitudes toward people with mental illness; they result in discriminatory behaviours and practices. These stereotypes lead to expectations that people with mental illness will fail when looking for a job, living independently or building long-term relationships. The truth is employers are reluctant to hire people with psychiatric disabilities; landlords are less likely to rent apartments to them; and supportive housing is not welcome in most neighbourhoods.

The negative reaction to mental illness leads to discrimination that can be as hard for people to deal with as the symptoms of the disorder itself. For people with mental illness, stigma can be a barrier to finding a place to live, finding a job, finding friends, building a long-term relationship and connecting to the broader community — things that everyone needs for mental health.

"There are definitely a lot of stereotypes out there about mental illness. People have ideas based on what they've seen in movies, the media and their own day-to-day experiences. A lot of these stereotypes aren't accurate, and they don't foster a sense of caring for people who are mentally ill. It's important to address those stereotypes, and to work to change them."

(A participant in the program)

Why an awareness program?

Many people are frightened of mental illness, although about one in four people will require professional help for a mental health problem at some time in their lives.

Providing accurate information can help correct fears, myths and misconceptions many people have about mental illness. Studies have shown that a combination of education and face-to-face interaction has a greater impact on changing attitudes than using either strategy in isolation. Stigma is diminished when someone meets a person with mental

illness who contributes to the life of the community.

Negative perceptions can change when people have positive interactions with individuals with mental illness. The Talking About Mental Illness program provides an opportunity for this positive interaction within a learning environment. By providing accurate information and opening up dialogue between students and people who have experienced mental illness, the program helps correct misconceptions and provides insight into living with a mental illness.

"It gave me a better understanding of people with mental illness. I think I will feel much more comfortable around them now."
(Student who participated in the program)

Secondary schools provide an ideal environment and natural opportunities to address mental health and illness issues. Secondary school students, particularly at the senior level, are eager to learn. The Ontario curriculum guidelines for a number of senior-level courses, such as Challenge and Change in Society (Grade 12) and Healthy Active Living Education (Grades 11 and 12), contain explicit requirements for mental health education. These and other courses that lend themselves to exploring issues related to mental health are listed and described in Appendix A. The Talking About Mental Illness program provides teachers with a student-friendly way of meeting the learning objectives and the curriculum requirements.

How does the program help to eliminate stigma?

To truly understand the extent of stigma associated with mental illness and its effects, and to find ways to act to change it, we need to hear from people who have experienced it first-hand. In the program, people who have lived with mental illness share their stories with the students. The program teaches that people with mental illness are not violent or incompetent, and that, in one student's words, "they are just like everybody else." The students learn that with advances in treatment and community support, people with mental illness, just like people with other chronic health problems such as diabetes, can live fulfilling lives and contribute to the community.

"The stories helped me to see that mental illness can happen to anyone, even someone who is doing well in life."
(Student who participated in the program)

"The students come back with a better understanding of people with mental illness as not leading separate and distinct lives...There are no signposts anywhere that distinguish people with mental illness from anyone else."
(Teacher who participated in the program)

In the program evaluation, students' knowledge and attitudes about mental illness and people with mental illness were measured — both before and after they took part in the program. The results showed that the program increases knowledge and awareness of mental illness and fosters more positive attitudes about people with mental illness. For information on how the program was evaluated, refer to Section 2.

What does this program offer young people?

The program has been shown to have several important outcomes for youth — positively influencing both their attitudes and knowledge about mental illness.

Secondary school students are at an age where they are forming opinions and values that will be with them for life. This program helps students develop critical thinking skills by encouraging them to examine media messages and their own preconceptions about mental illness. It helps ensure students develop a strong sense of understanding, empathy, compassion and tolerance — essential elements in healthy individuals and caring communities.

Teenagers need to know more about mental illness because the first symptoms of severe, chronic forms of mental illness (such as schizophrenia, bipolar disorder, panic disorder and obsessive-compulsive disorder) generally appear between the ages of 16 and 24. Young people with disorders such as schizophrenia and mood disorders have a very high risk of attempted suicide. Suicide is the second most common cause of death among Canadian youth, surpassed only by accidental deaths (Health Canada, 1994).

A recent study (Oliver et al., 1995) highlighted the extent of mental health concerns among Canadian youth and the barriers that influence their attitudes, coping skills and help-seeking behaviours. The study's findings confirmed the results of earlier research such as the Canadian Youth Mental Health Survey (1993), which found that depression, stress, suicide and eating disorders are issues of concern for teens, and that fear, embarrassment, peer pressure and stigma are barriers to getting help.

The program provides an opportunity to openly discuss mental illness. However, this discussion does not replace professional help. It provides the kind of information, such as local mental health-related resources, that makes it easier for young people to find help and support for themselves and others to deal with mental illness. Teachers, organizers and presenters should emphasize that people experiencing distress should seek professional support.

Young people's attitudes toward seeking help and their desire to learn more about mental health issues can be positively influenced through educational initiatives. In one study, the authors report that educational presentations about suicide and depression were positively related to attitudes toward seeking help (Battaglia et al., 1990). Favourable attitude

"Several things come through loud and clear. Kids develop tremendous empathy and understanding of what it must be like to be in the presenter's shoes, which is a huge step. They also gain respect for the battle that people with mental illness fight, and witness the courage that it takes to fight that battle."

(Teacher who participated in the program)

"I can lecture and talk all I want, but in a few minutes, when the presenters relate their particular situation or story, it can cut through a whole lot of distance and make the learning real and focused for students."

(Teacher who participated in the program)

"What I liked most was the way I was able to ask questions about anything."

(Student who participated in the program)

"What I liked most about the program was the way we were able to see real people with their everyday struggles, not just text-book information."

(Student who participated in the program)

"I do this to educate them because I'm concerned that maybe one or two of these kids are going to have mental illness and they're not going to know what to do. Maybe my experience will help them."

(Presenter in the program)

"We know that many students are experiencing stress in their lives, either because their parents or students themselves are having emotional difficulties. The program gives students permission to acknowledge that a lot of us have these difficulties, and that it's OK to talk about it."

(Teacher who participated in the program)

change among junior and senior secondary school students has been noted following educational presentations delivered by medical personnel and presentations accompanied by personal contact with individuals identified as having a mental illness (Godschalx, 1984; Mound & Butterill, 1992).

OVERVIEW OF THE PROGRAM

What is the purpose of the program?

The Centre for Addiction and Mental Health, the Canadian Mental Health Association Ontario Division and the Mood Disorders Association of Ontario have worked together to develop a community-based awareness program for youth aged 16 and older. This program is modeled after "Beyond the Cuckoo's Nest," an awareness program for secondary school students that has been operating out of the former Clarke Institute of Psychiatry, now part of the Centre for Addiction and Mental Health, for 14 years.

The program involves local community partners in developing and organizing an awareness presentation that is hosted by local secondary schools. Partners include youth, people with mental illness and their family members, clinicians, teachers, mental health and other agency representatives.

What are the goals and objectives of the program?

- to eliminate or reduce the stigma associated with mental illness
- to provide teachers/educators with appropriate support and materials to implement the awareness program
- to organize awareness presentations to take place in local secondary schools or other community venues
- to provide an opportunity for secondary school students to learn from people who have experienced mental illness first-hand
- to provide secondary school students with information about mental illness and related local resources
- to provide support, ideas and resources for teachers to deliver new mental health-related curricula.

Where does the program fit?: Links with the Ontario Ministry of Education and Training's curriculum guidelines

The curriculum for secondary schools presents many opportunities to teach students about mental health and mental illness, both formal and informal.

Formal opportunities

The formal opportunities are found in two main areas of the secondary school curriculum that address mental health issues — health and physical education, and the social sciences and humanities. The particular courses in which there is a good fit are listed in Appendix A of this resource. We have highlighted the relevant sections of the Ontario Secondary School Curriculum Guidelines for these courses, so that it will be easy to see where the program fits.

The Talking About Mental Illness program is not an add-on to the curriculum requirements, but is, rather, a way of helping teachers meet those requirements for a number of courses. The activities contained in the Teacher's Resource are student- and teacher-friendly, and easy to implement.

Additional opportunities

Informal opportunities or "teachable moments" also occur across the curriculum. For example, in English class, the experience of a character in a novel can be used to explore the attitudes expressed by society toward mental illness. In art, students can view the work of artists who have experienced mental illness and discuss the potential connection between their illness and the creative process. These courses and others provide easy entry points for discussion about how beliefs, attitudes and knowledge about mental illness have changed over time.

Looking at your school: School information survey

Answering the following questions with a member of the program's organizing committee will help you find out more about the context of mental health issues in your school and community. Several student representatives should also be invited to participate in this discussion. It's a good opportunity to develop student interest and participation in the program.

- What are the major cultural and ethnic groups present in the school? (Different ethnic and cultural groups may have different perceptions/attitudes toward mental illness.)
- Are there any recent events or traumatic incidents in the school or broader community (e.g., suicide attempt) that have affected the student body and teaching staff, events that might influence people's perceptions of mental health issues?
- Have there been any serious problems associated with drug use in the school or community? (e.g., overdose, hospitalization).
- What is the role of your guidance department in providing support to students?
- Are mental health and mental illness discussed in the classroom, either as part of the curriculum or informally?
- Has your school hosted, or participated in, an educational event on mental health or mental illness? If so, how long ago? Please describe the experience.

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FOR FURTHER READING

Fink, P. & Tasman, A. (Eds.). (1992). *Stigma and Mental Illness.* Washington, DC: American Psychiatric Press.

This book contains a series of papers that came out of a 1989 American Psychiatric Association annual meeting. The theme of that meeting was Overcoming Stigma and the papers presented discuss societal, historical and institutional issues of stigma. The papers also include narratives of people with mental illness.

Peterson, D. (Ed.). (1982). *A Mad People's History of Mental Illness.* Pittsburgh: University of Pittsburgh Press.

This book examines the history of treatment of people with mental illness from 1436 to 1976 by means of excerpts from the writings of people who received treatment. It is a unique history presented through the eyes of individuals as they experienced mental illness.

Sattler, D.N., Shabatay, V. & Kramer, G. (1998). *Abnormal Psychology in Context: Voices and Perspectives.* New York: Houghton Mifflin.

This book is a collection of first-person accounts and narratives, written by individuals who have had psychiatric disorders of various kinds. It's a companion text for college psychology courses, adding the voices and experiences of real people to the usual textbook description of symptoms and diagnoses. Comments by therapists and relatives of those with mental disorders are also included.

Wahl, O.F. (1995). *Media Madness: Public Images of Mental Illness*. New Jersey: Rutgers University Press.

This book describes how mass media (television, books, newspapers, movies, advertising, etc.) depict people with mental illnesses. It also discusses the impact of media stereotypes of mental illness, provides facts about mental illness and gives examples of efforts to improve media portrayals of mental illness.

Wahl, O.F. (1999). *Telling is Risky Business: Mental Health Consumers Confront Stigma*. New Jersey: Rutgers University Press.

Telling is Risky Business vividly covers such topics as isolation, rejection, discouragement and discrimination, as well as strategies for coping. It includes a section on resources for fighting stigma.

SECTION 2: CONTENT OF THE PROGRAM

PROGRAM OUTLINE

Teachers can adapt the format of the program to suit their classroom and the amount of time they have available. This chart provides a template from which teachers can select learning activities that address the educational components around which the program is based.

The structure of each component is flexible. Each one contains activities and resources that can be adapted for use in a number of courses. The way teachers use the activities and resources will depend on several things: which course the program is being incorporated into; how much time the teachers have available; and where they are in the course outline when they take part in the program.

PROGRAM COMPONENTS

Day 1 **Component 1: Stigma: What is it? How does it affect people's lives?**
- involves a discussion of stigma and its impact on the lives of people with mental illness

Day 2 **Component 2: What is mental illness?**
- provides a basic overview of the major mental illnesses, their causes and treatment

Day 3 (or 3 and 4) **Component 3: The presentation**
- organized by the local committee
- conducted within the classroom or secondary school setting
- consists of a variety of speakers, including people with different types of mental illness

Day 4 (or 5) **Component 4: Follow-up activities and resources**
- provides a number of suggestions for: debriefing the presentation, encouraging students to take action, and finding additional information.

Note to teachers

The "Talking about Mental Illness" program aims to provide the kind of information that helps to break down stereotypes and stigmatization of all of the major mental illnesses. Teachers have expressed a strong need for this kind of information because the secondary school years are often the time when major mental illnesses begin to develop.

In our experience, the discussion of some of these topics, particularly eating disorders and suicide, tends to elicit a strong reaction from students and needs to be handled carefully.

Before implementing any of the program-related activities, we suggest you read the following recommendations and best advice we have gathered for navigating these issues in the classroom. For more specific recommendations on preparing your students for the presentation, please see Component 3: The Presentation.

Eating disorders

Eating disorders are not always subject to the same kind of stigmatization as other forms of mental illness, and may, especially among secondary school girls, be perceived as glamorous. We have received some feedback questioning the appropriateness of treating eating disorders in the same way as other forms of mental illness that are included in the program.

The following are a few recommendations gathered from teachers who have implemented

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the program, as well as experts on eating disorders, that may help to ensure discussion is informative and constructive.

- It is important to clarify that "eating disorders" refers to a broad spectrum of behaviours that ranges from eating-disordered behaviour to full-blown eating disorders.

- Eating disorders should be viewed as a broad social issue, within the context of a culture that promotes unrealistic and unhealthy standards of beauty, as depicted in the mass media.

- Adolescents are particularly vulnerable to these images and unrealistic expectations because of peer pressure, as well as the contextual pressures of adolescence (such as physical changes that come about as a result of puberty, and changing expectations of social roles).

- Attempts to provide education around eating disorders should therefore take a comprehensive approach, and focus on the broader levels of the school environment, the community and society at large.

- It may be helpful to ask students to share some of their perceptions and beliefs around eating disorders before the presentation. This would allow the presenters to tailor their talk to address some of the issues and myths that students mention.

- A dietitian or nutritionist could be invited to the classroom to provide information about nutrition and eating disorders before the presentation takes place. It may be helpful for this person to stress that dieting and restricted eating can, for some people, start slipping beyond the person's control into an eating disorder. Introducing the potential medical implications of eating disorders (e.g. that women/girls with anorexia can lose the hair on their heads and grow more hair on their bodies and faces; that the disorder can cause disruption to menstruation and fertility, loss of bone mass, changes in brain structure, and heart complications) might help emphasize that they are serious illnesses, and not at all glamorous.

- Emphasize to presenters that their presentation should focus on their emotional, physical, and spiritual experiences with the illness, but that it should not provide specifics around the methods of weight loss, such as purging.

- Include a discussion about the influence of media on eating/dieting behaviours and self-image. Provide students with information about the ways in which body images are distorted and edited by the media. It might help shift students' ideas about the "ideal" body shape and the glamorous images that may be attached to eating disorders.

Suicide

Although "Talking About Mental Illness" is not a suicide prevention program, we recognize it is important to address the issue of suicide, both in its relationship to mental illness and as an issue

surrounded by stigma. Additionally, because suicide continues to be the second most common cause of death among Canadian youth, it is important to include information about suicide among the range of topics addressed in the program.

The following are a few recommendations gathered from teachers who have implemented the program, as well as experts on adolescent suicide prevention. They may help ensure the discussion is informative and constructive.

- Emphasize that diagnosis and treatment of mental disorders has been, and continues to be, a cornerstone of suicide prevention. A percentage of people who take their lives appear to have been suffering from depression when they committed suicide. However, not all people who choose to end their lives are mentally ill or display symptoms of their distress before they commit suicide.

- Ensure there are close links with professional mental health resources in the community. The local organizing committee will be able to provide teachers with a list of mental health professionals and services available in the community. The committee can also help arrange for a service provider to attend the presentation to provide information on local mental health services, and to respond to students who may be upset as a result of something they hear in the presentation. For example, a student might have a concern about his or her own well-being after hearing presenters discuss the symptoms of their mental illness and/or the circumstances associated with the onset of symptoms. Having a mental health professional available to answer questions during the presentation and afterwards can help answer students' concerns and steer them toward additional sources of information and support.

- Adolescents need to be reassured they have someone to whom they can turn — be it family, friends, school counsellor, physician, or teacher — to discuss their feelings or problems. It must be a person who is very willing to listen and who is able to reassure them that depression and suicidal tendencies can be treated. Teachers can play a role in this area by reminding students of the resources within the school and the community and highlighting how these services can be accessed. It is a good idea to prepare a handout for students, containing the phone numbers and addresses of local mental health services and help lines. Then, if students feel uncomfortable talking about their concern in front of their peers, they will have information about how to connect with a service provider at a time that is better suited to them.

- Presenters will be instructed to avoid providing any detailed information about their suicidal feelings or attempts. Presenters will be asked to keep their account focused on how the symptoms of their mental illness were related to their suicidal ideation, and that once their symptoms were treated, their suicidal feelings were relieved. Presenters should be encouraged to speak about their treatment in concrete terms, such as by saying, "I went to see my family doctor/counsellor, and began to feel better...", "Attending my weekly support group really helped me...", or "It also helped to talk about my feelings with my friends/family/counsellor...".

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- Schools should have in place a protocol for suicide prevention that is well communicated to staff, health professionals and speakers participating in the awareness program. The protocol should be explicit and include how to talk to someone who appears to be upset by the presentation and possibly "at risk" of suicide. The protocol should also identify the appropriate person to make the intervention, under what circumstances the contact should be made, how confidentiality and its limits should be discussed, and how to ensure a safe hand-off to a mental health professional if necessary. Another very important component that should be covered is post follow-up — what action should be taken after the intervention to ensure the individual gets appropriate help and support.

Suicide prevention is a complex area. A number of organizations and agencies offer information and training on this issue that is geared to the needs of teachers, counsellors, nurses and other caregivers. For a list of these resources please see Appendix G.

COMPONENT 1 — STIGMA: WHAT IS IT? HOW DOES IT AFFECT PEOPLE'S LIVES?

Rationale

It is helpful to introduce the concept of stigma to students before the presentation, and to brainstorm about the ways mental illness is stigmatized in our society. The tools and activities in this section challenge students to examine their own biases and stigmatizing attitudes, and prepare them to listen to the presentation with open ears.

This introductory session may also be a good opportunity to view one of the audiovisual resources that are available from the National Film Board. Please see Appendix F for further details.

Overview of Educational Activities

1) Free association activity

2) What is stigma?

3) Case studies that examine the impact of stigma

4) Art and literature activity

5) Famous people with mental illness

OVERHEADS AND HANDOUTS NEEDED

Overhead 1 — What Is Stigma?

Overhead 2 — Terms Related to Stigma

Overhead 3 — Famous People with Mental Illness

Handout 1 — Case Study

Examples of works of literature written by people with mental illness, or in which major characters are affected by mental illness. See Appendix B for sources.

Educational activities: Descriptions, instructions and tools for Component 1

> Activity 1: Free association exercise

(adapted from the "Face to Face with Mental Illness" program, developed by the Canadian Mental Health Association, London-Middlesex Branch and St. Thomas Aquinas Catholic School, London, ON.)

PURPOSE: To get an idea of students' knowledge about mental illness and what their fears and misconceptions might be. It is also an icebreaker to encourage students to participate in the discussion.

It is important to emphasize there are no wrong answers — the exercise is all about opening up a discussion. Tell students they don't have to believe in, or agree with, the ideas or names they offer.

MATERIALS: Cue cards, masking tape and markers.

TIME: 15–20 minutes.

INSTRUCTIONS: Ask students about the first things that come to mind when they think of mental illness or a person with mental illness. Get them to write these ideas down on cue cards. Be sure to tell them there are no right or wrong answers; that it is an opportunity to bring up anything that comes to mind. Encourage them to write down as many ideas as they can, then stick the cue cards on the walls.

Once all the responses are on the wall, the teacher facilitates a discussion about which of the following categories each one fits into:

- myth (widely held, but false idea)
- misconception or misunderstanding
- hurtful or disrespectful language
- factual information.

Typically, the majority of responses will fit into the first three categories. Grouping the responses into the categories will reveal common themes. Some common themes that may emerge will be myths and misconceptions, such as the idea that people with mental illness are dangerous.

It is important to address all of the students' comments in the context of stigma by demystifying myths, addressing fears and misconceptions, and examining their underlying causes. Ask students to think about where such ideas come from — for example, the roles that media, movies, books and personal experience play in forming thoughts, attitudes and beliefs about mental illness. Many of the issues that come up will be addressed in the Fact or Fiction? activity that is included in Component 2.

> Activity 2: What is stigma?

PURPOSE: To get students to explore the concept of stigma, its causes and its impact. The definitions provided on the overhead may stimulate discussion about the origins of stigma and the use of the term in relation to mental illness.

MATERIALS: the discussion guide below, Overhead 1 — What Is Stigma?, Overhead 2 —Terms Related to Stigma, overhead projector.

TIME: 10–15 minutes, depending on the size of the audience.

INSTRUCTIONS: Ask students the following questions. If they are slow to respond, try to make connections between this topic and their responses to the free association exercise.

1) Can anyone tell me what stigma is?

Possible answers include: labels like crazy, psycho; stereotyping or discrimination.

- Use Overhead 1 — What Is Stigma? and Overhead 2 — Terms Related to Stigma to define and discuss stigma and related terms. Tell students everyone has had discriminatory or stigmatizing thoughts or attitudes. Remind them the important things are: to recognize discriminatory or stigmatizing thoughts and attitudes; to examine where they come from; and to work toward controlling and changing the hurtful behaviours they may cause.

2) What are some of the negative things you have heard about people with mental illness?

- If not mentioned by the group, repeat any examples from the responses to the free association exercise at the beginning of the presentation.

3) What are some of the positive things you have heard about people with mental illness?

- Some people say those with mental illness are creative and artistic. While this may seem positive, you may want to remind students it is also a form of stereotyping.

4) Why do you think people with mental illness are stigmatized?

Possible answers include: They are seen as being different; People don't understand what mental illness is.

5) Can you think of any other health conditions or social issues that have been stigmatized throughout history?

Possible answers include: homosexuality, leprosy, unwed motherhood, divorce, AIDS.

6) What kinds of factors have contributed to changing public perceptions around some of these conditions or issues?

Possible answers include: education, public policy, open dialogue, scientific research, changing social mores.

7) What do you think influences perceptions about people with mental illness?

Possible answers include: the media — news, newspaper headlines and stories that associate people with mental illness with violence or suicide; the fact that people with mental illness sometimes behave differently and people are afraid of what they don't understand.

8) How do you think stigma affects the lives of people with mental illness?

Possible answers include: It makes them unhappy; They may not be able to get a job or find housing; It may prevent someone from seeking help; It may cause them to lose their friends; It can negatively affect the whole family.

WHAT IS STIGMA?

The following are definitions of "stigma" taken from different sources and from different historical periods:

"A mark or sign of disgrace or discredit."

"A visible sign or characteristic of a disease."

— *The Concise Oxford Dictionary, 1990*

"An attribute which is deeply discrediting"

— *Goffman, E., Stigma: The management of spoiled identity, 1963*

"A distinguishing mark or characteristic of a bad or objectionable kind; a sign of some specific disorder, as hysteria."

"A mark made upon the skin by burning with a hot iron, as a token of infamy or subjection; a brand."

"A mark of disgrace or infamy; a sign of severe censure or condemnation, regarded as impressed on a person or thing."

— *The Shorter Oxford English Dictionary*

TERMS RELATED TO STIGMA

stereotype

"a person or thing that conforms to an unjustifiably fixed impression or attitude"

prejudice

"a preconceived opinion"

discrimination

"unfavourable treatment based on prejudice"

— *The Concise Oxford Dictionary, 1990*

> Activity 3: Case studies

PURPOSE: To illustrate different ways we treat people with mental versus physical illnesses and the impacts our attitudes and assumptions have on other people's lives.

MATERIALS: Handout 1 — Case Study and discussion guide on the following pages

TIME: 10–15 minutes.

INSTRUCTIONS: Distribute Handout 1 — Case Study to the students and give them five minutes to read it. You can choose whether you want the students to work in small groups or individually. When students have read the handout, use the questions in the discussion guide to explore different assumptions made by community members, employers, medical personnel and family members toward Frank's versus Alice's illness.

QUESTIONS FOR DISCUSSION:

1) If both suffer from chronic biological illnesses, why did Frank lose his job, his apartment and his friends while Alice's situation remained relatively unchanged?

2) What kinds of assumptions underlie the actions of health professionals, family and friends in each situation?

3) Are friends, work, independence, recreation and family support equally important for people with mental illness and people with other chronic illnesses?

CASE STUDY

FRANK JONES

Frank Jones had been released from a provincial psychiatric hospital after having been admitted recently for intense psychotic symptoms. At the time of admission, Frank was highly agitated, yelling that the police were going to harm him because he's the Boston Strangler's brother. In the emergency room, Frank told the on-call psychiatrist that he was hearing voices of the devil preaching about his murderous relatives.

This was the patient's third hospitalization since schizophrenia was first diagnosed 12 years earlier at age 22. Frank had made an excellent recovery from previous hospital stays: He had been working as a salesman at a hardware store for the past six years, and lived nearby in a small but comfortable apartment. He visited a psychiatrist at the community mental health centre for medication about once a month. He also met with a counsellor there to discuss strategies to cope with his mental illness. Frank had several friends in the area and was fond of playing softball with them in park district leagues. He had been dating a woman in the group for about a year and reported that he was "getting serious." Frank was also active in the local Baptist Church, where he was co-leading Bible classes with the pastor. The reappearance of symptoms derailed his job, his apartment and his social life.

Recuperating from this episode involved more than just dealing with the symptoms of his illness. The reaction of friends, family members and professionals also affected what happened to Frank. The hardware store owner was frightened by Frank's "mental hospitalization." The owner had heard mentally ill people could be violent, and worried that the stress of the job might lead to a dangerous outburst in the shop. Frank's mother had other concerns. She worried the demands of living alone were excessive: "He's pushing himself much too hard

trying to keep that apartment clean and do all his own cooking," she thought. She feared Frank might abandon his apartment and move to the streets, just like other mentally ill people she had seen.

Frank's doctor was concerned his hospitalization signaled an overall lack of stability. His doctor believed schizophrenia was a progressively degenerative disease, a view first promoted by a renowned psychiatrist in 1913. In this view, psychiatric hospitalizations indicated the disease was worsening. The doctor concluded Frank's ability to live independently would soon diminish; it was better to prepare for it now rather than wait for the inevitable loss of independent functioning. So the doctor, with the help of Frank's mother and boss, talked him into leaving his job, giving up his apartment and moving in with his mother. Frank's mother lived across town, so he stopped attending the Baptist church. Frank was unable to meet with his friends and soon dropped out of the sports league. He stopped seeing his girlfriend. In one month, he lost his job, apartment and friends.

ALICE JOHNSON

Like Frank Jones, Alice Johnson had been diagnosed with a significant and chronic disease: diabetes. She had to carefully monitor her sugar intake and self-administer insulin each day. She watched her lifestyle closely for situations that might aggravate her condition. Alice also met regularly with a physician and a dietitian to discuss blood sugar, diet and exercise. Despite these cautions, Alice had an active life. She was a 34-year-old clerk-typist for a small insurance broker. She belonged to a folk-dancing club she attended at a nearby secondary school. She was engaged to an accountant at the insurance company.

Despite carefully watching her illness, Alice suffered a few setbacks, the last occurring about a month ago when she required a three-day hospitalization to adjust her medication. The doctor recommended a two-week break from work after her discharge, and referred her to the dietitian to discuss appropriate changes in lifestyle. Even though diabetes is a life-threatening disease (in her

most recent episode. Alice was near coma when she was wheeled into the hospital), no one suggested she consider institutional care where professionals could monitor her blood sugar and intervene when needed. Nor did anyone recommend Alice give up her job to avoid work-related stressors that might throw off her blood sugar.

Case studies adapted from Corrigan, P. (1998). The Impact of Stigma on Severe Mental Illness. Cognitive and Behavioral Practice, 5, *201-222.*

> Activity 4: Art and literature

PURPOSE: Exposing the audience to the art and literature of people with mental illness will present different perspectives of the experience of mental illness as it is expressed creatively. This activity provides an opportunity to examine changes in society's understanding and acceptance of mental illness and those who are affected by it.

MATERIALS: There are examples throughout the secondary school curriculum of works of literature written by people with mental illness, or in which major characters are affected by mental illness. Some of these include: William Shakespeare's *Macbeth* and *King Lear*, J.D. Salinger's *The Catcher in the Rye*, Emily Brontë's *Wuthering Heights* and Sylvia Plath's *The Bell Jar*.

A list of resources for consumer-survivor art and literature can be found in Appendix B. Use overheads to display visual art. Literature can be read out loud or even performed.

TIME: It can take as little as five minutes to read a selected poem and discuss its possible meaning with the students.

INSTRUCTIONS: Be creative.

> Activity 5: Famous people with mental illness

PURPOSE: To emphasize that mental illness is not a barrier to achievement.

MATERIALS: Overhead 3 — Famous People with Mental Illness, listing famous people — artists, politicians, writers, historical figures, etc. — who experienced mental illness is located on the next page.

TIME: 5–10 minutes

INSTRUCTIONS: Explain the purpose of showing students the names of famous people with mental illness.

Emphasize that just like the rest of us, people with mental illness live ordinary lives: they have families, jobs, bills to pay, talents, challenges, and so on. There are also people who have a harder time dealing with their mental illness and don't function as well as the presenters or the famous people on the list. This may be due to factors such as lack of support, lack of affordable housing or treatment as well as stigma.

Read through the list or just leave the overhead up for students to pick out the names they recognize.

FAMOUS PEOPLE WITH MENTAL ILLNESS

(Diagnosis or believed diagnosis of mood disorder, unless otherwise indicated)

ACTORS/ENTERTAINERS/DIRECTORS

Marlon Brando

Drew Carey

Jim Carrey

Dick Clark

John Cleese

Rodney Dangerfield

Richard Dreyfuss

Patty Duke

Frances Ford Coppola

Audrey Hepburn

Anthony Hopkins

Ashley Judd

Margot Kidder

Vivien Leigh

Joan Rivers

Roseanne

Winona Ryder

Charles Schultz

Rod Steiger

Damon Wayans

Robin Williams

ARTISTS

Paul Gaugin

Vincent van Gogh

Michelangelo

Vaslov Nijinski (schizophrenia)

Georgia O'Keefe

Jackson Pollock

ATHLETES

Lionel Aldridge (schizophrenia)

Oksana Baiul

Dwight Gooden

Peter Harnisch

Greg Louganis

Elizabeth Manley

Jimmy Piersall

Monica Seles

Darryl Strawberry

Bert Yancey

AUTHORS/JOURNALISTS

Hans Christian Andersen

James Barrie

William Blake

Agatha Christie

Michael Crichton

Charles Dickens

Emily Dickinson

William Faulkner

F. Scott Fitzgerald

John Kenneth Galbraith

Ernest Hemingway

John Keats

Larry King

Eugene O'Neill

Sylvia Plath

Edgar Allen Poe

Mary Shelley

Neil Simon

William Styron

Leo Tolstoy

Mark Twain

Mike Wallace

Walt Whitman

Tennessee Williams

Virginia Woolf

BUSINESS LEADERS

Howard Hughes (depression & OCD)

J.P. Morgan

Ted Turner

SCIENTISTS

Charles Darwin

Sigmund Freud

Stephen Hawking

Sir Isaac Newton

COMPOSERS/MUSICIANS/SINGERS

Irving Berlin

Ludwig van Beethoven

Karen Carpenter (anorexia)

Ray Charles

Frederic Chopin

Eric Clapton

Kurt Cobain

Leonard Cohen

Natalie Cole

Sheryl Crow

John Denver

Stephen Foster

Peter Gabriel

Janet Jackson

Billy Joel

Elton John

Sarah McLachlan

Charles Mingus

Alanis Morissette

Marie Osmond

Charles Parker

Cole Porter

Bonnie Raitt

Axl Rose

Robert Schumann

Paul Simon

James Taylor

Peter Tchaikovshy

POLITICAL FIGURES/WORLD LEADERS

Alexander the Great

Napoleon Bonaparte

Barbara Bush

Winston Churchill

Diana, Princess of Wales

Tipper Gore

Thomas Jefferson

Ralph Nader

Florence Nightingale

George Patton

George Stephanopolous

(Taken from the Mood Disorders Web site: www.ndmda.org)

COMPONENT 2 — WHAT IS MENTAL ILLNESS?

RATIONALE

Many students do not know basic facts about mental illness; furthermore, they may have misconceptions that need to be corrected. They benefit from learning about the causes of mental illness and the kinds of treatments available to people with mental illness.

Understanding some of the basic terms related to mental illness helps students get the most out of presenters' stories. A basic familiarity with some of the language used by presenters helps students tune into the personal aspect of the presenters' experiences. It also makes students feel more comfortable and encourages them to ask questions.

The specific content of the pre-presentation lessons in Component 2 include: definitions of the major mental illnesses; incidence of different kinds of mental illness in the population; causes of the most common mental illnesses; and treatments currently available.

Because of the somewhat technical nature of the information contained in this component, teachers often request the support of local mental health professionals to help them deliver this information. Members of the organizing committee can put teachers in touch with local mental health professionals (often members of the committee themselves) who would help in the classroom.

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Overview of Educational Activities

1) Fact or fiction?

2) Mental illness statistics for Ontario

3) Understanding mental illness: Definitions, possible causes and treatment

4) Auditory hallucinations

Overheads and handouts needed

Overhead 4 — Fact or Fiction?

Overhead 5 — Mental Health Statistics for Ontario

Overhead 6 — Definition of Mental Illness

Overhead 7 — Factors that May Contribute to the Development of Mental Illness

Overhead 8 — Treatment of Mental Illness

Handout 2 — "Voices" Script (two copies)

Educational activities: Descriptions, instructions and tools for Component 2

> Activity 1: Fact or fiction?

PURPOSE: To debunk some of the myths about mental illness.

MATERIALS: Overhead 4 — Fact or Fiction? and answer key located on the next few pages.

TIME: 15–20 minutes.

INSTRUCTIONS: Use Overhead 4 — Fact or Fiction? to test students' knowledge of the facts about mental illness. Read each of the statements, one by one, asking whether the statement is true or false. Use the answer key (page 42) to discuss the students' responses and the correct answers.

FACT OR FICTION?

1. One person in 100 develops schizophrenia. True or False
2. A person who has one or two parents with mental illness is more likely to develop mental illness. True or False
3. Mental illness is contagious. True or False
4. Mental illness tends to begin during adolescence. True or False
5. Poor parenting causes schizophrenia. True or False
6. Drug use causes mental illness. True or False
7. Mental illness can be cured with willpower. True or False
8. People with mental illness never get better. True or False
9. People with mental illness tend to be violent. True or False
10. All homeless people are mentally ill. True or False
11. Developmental disabilities are a form of mental illness. True or False
12. People who are poor are more likely to have mental illness than people who are not. True or False

Fact or fiction? — answer key

1. One person in 100 develops schizophrenia.

True. One per cent of the general population develops schizophrenia.

2. A person who has one or both parents with mental illness is more likely to develop mental illness.

True. Mental illness can be hereditary. For example, the rate of schizophrenia in the general population is one per cent. This rate rises to to eight per cent if one parent has the disorder and to 37–46 per cent if both parents have it. One in 10 people in the general population has experienced depression, compared to one in four for people whose parents have experienced depression.

3. Mental illness is contagious.

False. Mental illness is not contagious. Heredity can, and often does, play a factor in the development of the disease.

4. Mental illness tends to begin during adolescence.

True. The first episode of a mental illness often occurs between the ages of 15 and 30 years. Early intervention is currently thought to be one of the most important factors related to recovery from mental illness. Embarrassment, fear, peer pressure and stigma often prevent young people from seeking out help.

5. Poor parenting causes schizophrenia.

False. Childhood abuse or neglect does not cause mental illnesses such as schizophrenia. However, stressful or abusive environments may seriously impair a person's ability to cope with and later manage the illness.

6. Drug use causes mental illness.

True and False. Alcohol and other drugs sometimes play a role in the development of some symptoms and disorders, but do not usually cause the illness. However, long-term drug and alcohol use can lead to the development of drug-induced psychosis, which has many of the same symptoms of organic mental illness. Alcohol and drugs are often used as a means to cope with the illness, although using alcohol and drugs can make the symptoms of mental illness worse.

7. Mental illness can be cured with willpower.

False. Mental illness is associated with chemical imbalances in the brain and requires a comprehensive treatment plan.

8. People with mental illness never get better.

False. With the right kind of help, many people with a mental illness do recover and go on to lead healthy, productive and satisfying lives. While the illness may not go away, the symptoms associated with it can be controlled. This usually allows the person to regain normal functioning. Medication, counselling and psychosocial rehabilitation are treatment options that can help people recover from mental illness.

9. People with mental illness tend to be violent.

False. People who experience a mental illness acutely sometimes behave very differently from people who do not. While some of their behaviours may seem bizarre, people with mental illness are not more violent than the rest of the population.

10. All homeless people are mentally ill.

False. Although studies have shown that between 17 and 70 per cent of people who are homeless have mental illnesses, it is clear that being homeless doesn't automatically indicate a mental illness.

11. Developmental disabilities are a form of mental illness.

False. Mental illness is often confused with developmental disabilities, even though the two conditions are quite different. Mental illness does not affect an individual's intellectual capacity, whereas developmental disabilities do. However, people with developmental disabilities are more susceptible to developing mental illness.

12. People who are poor are more likely to have mental illness than people who are not.

False. Income is not a factor in overall rates of mental health problems. However, people with lower incomes experience slightly higher rates of depression. People who live with major mental illnesses often end up in lower social classes because the illness may interfere with their ability to hold a job.

> Activity 2: Mental illness statistics for Ontario

PURPOSE: To provide students with a few basic statistics about the major mental illnesses. The statistics can inspire further investigation and discussion in the classroom.

MATERIALS: Overhead 5 — Mental Health Statistics for Ontario, located on the following page.

TIME: 10 minutes

INSTRUCTIONS: Use Overhead 5 — Mental Health Statistics for Ontario. If students want further information related to these statistics, please refer them to the document from which these statistics were taken, the Health Statistical Sourcebook Vol. 1: An Investigation into the Ontario Mental Health Supplement of the 1990 Ontario Health Survey. (February 1999). It can be found at the Web site of the Ontario Division of the Canadian Mental Health Association, at http://www.ontario.cmha.ca/mhic/omhss_v1.pdf

MENTAL HEALTH STATISTICS FOR ONTARIO

- 22 per cent of Ontarians have experienced at least one mental health problem in their lifetime.
- Women are more likely than men to experience a mental health problem, specifically anxiety or depression.
- Men are more likely to experience antisocial personality disorder.
- 31 per cent of 15- to 24-year olds have experienced a mental health problem:
  - 27 per cent have anxiety problems
  - 7.5 per cent have affective problems
  - 15- to 24-year-olds are more likely to have social phobias and bipolar disorder.
- Older people experience depression more often than younger people.
- Mental disorders (especially depression) are more common among people who are separated, divorced or widowed.
- 52 per cent of Ontarians whose parents have experienced a mental health problem also experience a mental disorder.

Source: Canadian Mental Health Association, Ontario Division, 1999

For further information, please refer the source document of these statistics.

It can be found on the Canadian Mental Health Association, Ontario Division's Web site:

http://www.ontario.cmha.ca/mhic/omhss_v1.pdf

> Activity 3: Understanding mental illness: Definitions, possible causes and treatment

PURPOSE: Most people have heard of at least some types of mental illness, but they may not have a full understanding of those illnesses. The objective of this activity is to inform students about different mental illnesses, as well as to correct misconceptions students may have regarding mental illness and treatment. Members of the organizing committee can be good resources if teachers need support in delivering the content of this component. Local mental health professionals with a clinical background and experience may be able to offer insight into the technical nature of this component.

This section is particularly useful for audiences who have had limited instruction about mental illness. The goal of this material is to offer a common framework for understanding mental illness and the different ways it is manifested in individuals. The amount of time you spend on this exercise will depend on how much formal teaching your students have had in this area.

MATERIALS

Overhead 6 — Definition of Mental Illness

Overhead 7 — Factors that May Contribute to the Development of Mental Illness

Overhead 8 — Treatment of Mental Illness

TIME: About five minutes to go through each overhead.

INSTRUCTIONS: Use Overhead 6 — Definition of Mental Illness to uncover students' knowledge of types of mental illness. Ask students to name some types of mental illness. As you read through the definitions, be sure to remind students of the following:

- Everyone experiences feelings of sadness, agitation or confusion, but people with mental illness experience these symptoms for extended periods of time; they experience a loss of ability to function and they are unable to bounce back without extensive medical attention and social support.
- Culture, age and gender influence each of these disorders, and different people may have different experiences with the illness.
- A person can experience one or more of these disorders at the same time.

Use Overhead 7 — Factors that May Contribute to the Development of Mental Illness and discussion guide (page 54) to discuss the factors related to the onset of mental illness.

Use Overhead 8 — Treatment of Mental Illness and discussion guide (page 56) to discuss the various conventional approaches to treating mental illness.

DEFINITION OF MENTAL ILLNESS

Mental illness is a disturbance in thoughts and emotions that decreases a person's capacity to cope with the challenges of everyday life.

DESCRIPTIONS OF MENTAL ILLNESSES — MOOD DISORDERS

Mood disorders are persistent changes in mood caused by biochemical imbalances in the brain. Major depressive disorder and bipolar disorder are two types of mood disorders.

Major depressive disorder is depressed mood accompanied by symptoms such as: loss of interest or pleasure in life; irritability; sadness; difficulty sleeping or sleeping too much; decreased or increased appetite; lack of concentration; sense of worthlessness; guilt; and in some cases, thoughts of suicide.

Bipolar disorder is a cycle of depressed mood, "normal" mood and mania. Mania is an elevated, exaggerated mood accompanied by symptoms such as: inflated self-esteem or confidence; a decreased need for sleep; increased energy; increased sexual drive; poor judgment; increased spending; agitation; non-stop talk; and increased involvement in pleasurable and possibly dangerous activities.

DESCRIPTIONS OF MENTAL ILLNESSES — PSYCHOSIS

Psychosis is the active state of experiencing hallucinations or delusions and can be organic (mental illness) or drug-induced.

Schizophrenia is a disturbance involving delusions, hallucinations, disorganized speech and/or disorganized or catatonic behaviour. Delusions are false beliefs or misinterpretations of situations and experiences. Hallucinations can be auditory, visual, olfactory (smell), gustatory (taste) or tactile (touch), but auditory hallucinations are most common. Schizophrenia is also associated with a deterioration of a person's ability to function at work, school and/or socially.

DESCRIPTIONS OF MENTAL ILLNESSES — ANXIETY DISORDERS

Anxiety disorders are associated with feelings of anxiousness, combined with physiological symptoms that interfere with everyday activities. Obsessive-compulsive disorder, phobias and post-traumatic stress disorder are types of anxiety disorders.

Obsessive-compulsive disorder is marked by repeated obsessions and/or compulsions that are so severe they interfere with everyday activities. Obsessions are disturbing, intrusive thoughts, ideas, or images that cause marked anxiety or distress. Compulsions are repeated behaviours or mental acts intended to reduce anxiety.

Post-traumatic stress disorder is the re-experiencing of a very traumatic event, accompanied by feelings of extreme anxiety, increased excitability and the desire to avoid stimuli associated with the trauma. The trauma could be related to such incidents as military combat, sexual assault, physical attack, robbery, car accident or natural disaster.

Phobias are significant and persistent fears of objects or situations. Exposure to the object or situation causes extreme anxiety and interferes with everyday activities or social life. Specific phobias have to do with objects or situations — for example, germs or heights. Social phobias have to do with social situations or performance situations where embarrassment may occur — for example, public speaking or dating.

DESCRIPTIONS OF MENTAL ILLNESSES — PERSONALITY DISORDERS

A personality disorder is a pattern of inner experience and behaviour that is significantly different from the individual's culture; is pervasive and inflexible; is stable over time; and leads to distress or impairment. Personality disorders usually begin in adolescence or early adulthood.

Dissociative identity disorder, formerly known as "multiple personality disorder," is the presence of two or more distinct identities that alternately control a person's behaviour. It reflects a failure to make connections between identity, memory and consciousness. Known by the general public as "split personality," there is now a controversy as to whether or not it is a real diagnosis.

DESCRIPTIONS OF MENTAL ILLNESSES — EATING DISORDERS

Eating disorders are a range of conditions involving an obsession with food, weight and appearance that negatively affect a person's health, relationships and daily life. Stressful life situations, poor coping skills, socio-cultural factors regarding weight and appearance, genetics, trauma, and family dynamics are thought to play a role in the development of eating disorders.

Anorexia Nervosa is characterized by an intense and irrational fear of body fat and weight gain, the strong determination to become thinner and thinner, the refusal to maintain a normal weight (for height and age) and a distorted body image.

Bulimia Nervosa is characterized by self-defeating cycles of binge eating and purging. Bingeing is the consumption of large amounts of food in a rapid, automatic and helpless fashion and leads to physical discomfort and anxiety about weight gain. Purging follows bingeing and can involve induced vomiting, restrictive dieting, excessive exercising or use of laxatives and diuretics.

(Eating Disorders Awareness and Prevention Web site: http://www.edap.org)

FACTORS THAT MAY CONTRIBUTE TO THE DEVELOPMENT OF MENTAL ILLNESS

The following are factors that may contribute to the development of mental illness:

- chemical imbalance
- substance use
- traumatic life events
- heredity
- other illnesses.

Factors that may contribute to the development of mental illness: Discussion guide

Although there is currently no agreement about the exact causes of mental illness, the following factors are recognized as playing a role in the development of various mental illnesses:

Chemical imbalance

There is growing evidence that mental illness may be partially caused by a chemical imbalance in the brain. Many people respond well to medications that address such an imbalance and many of the symptoms of their illness are reduced or eliminated.

Substance use

There is no clear causal relationship between substance use and the development of mental illness. People who have mental illness may use alcohol and other drugs to relieve some symptoms of their illness. However, substance use may actually worsen symptoms and delay proper diagnosis and treatment. There are also cases in which substance use has induced psychotic behaviour, both because of the chemical effect of the drug and because the drug unmasks a pre-existing mental illness.

Traumatic life events

Similar to substance use, traumatic life events can, in some instances, make people more vulnerable to developing mental illness. Instead of recovering from a situational depression (e.g., grief following the death of a loved one), some people may go on to develop a more profound, clinical depression.

Heredity

We are learning more about the role heredity plays in the development of mental illness. Researchers have found that with certain diagnoses, the likelihood of a child developing a mental illness is greater if one or both parents have a mental illness. Examples of diseases thought to have a genetic component include schizophrenia, bipolar disorder, obsessive-compulsive disorder and depression.

Other illnesses

People with conditions such as Alzheimer's, Parkinson's, dementia and brain damage (from strokes or accidents) experience memory loss and confusion. People can also develop chronic depression in conjunction with debilitating physical illness, or illnesses that alter their level of functioning.

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TREATMENT OF MENTAL ILLNESS

Biological treatments

- medication
- electroconvulsive therapy (ECT).

Psychosocial Interventions

- psychotherapy
- self-help groups
- family support and involvement
- community supports.

Treatment of mental illness: Discussion guide

Treatments vary according to the particular illness and the severity of the illness. Different types of treatment include biological interventions, such as medications and electroconvulsive therapy; and psychosocial interventions, such as psychotherapy, family support and involvement, self-help, vocational, recreational and housing support. For most people with a serious mental illness, a combination of approaches tends to be most effective in relieving symptoms.

Biological treatments

Medication

The types of medications most commonly used to treat mental illness fall into four categories: antipsychotics, antidepressants, mood stabilizers, and anxiolytics, or anti-anxiety medication.

Electroconvulsive therapy (ECT)

ECT, also referred to as "shock therapy," is a long standing, effective and often misunderstood treatment for acute depression. The patient is given an anaesthetic and a muscle relaxant, then an electric charge is applied to the brain, inducing a small seizure.

ECT has been both condemned and promoted in the mental health field and the media. In its early days, ECT was a cruder procedure, which sometimes resulted in short- and long-term memory loss (although it usually resolved after six months).

Today, ECT is a much gentler intervention proven to be an effective treatment for major depression and bipolar depression or mania. Most people are unaware of the newer procedures and remain fearful of ECT, so they tend to try several medications before considering ECT as a treatment.

Psychosocial interventions

Psychotherapy

Psychotherapy is often used in conjunction with medication to treat mental illness. Psychotherapy is a general term used to describe a form of treatment based on "talking work" done with a therapist. The aim of talk therapy is to relieve distress by expressing feelings; to help change negative attitudes, behaviour and habits; and to promote constructive ways of coping.

There are many different types of therapy, including short-term, long-term, individual and group. An essential component of any psychotherapy is a supportive, comfortable relationship with a trusted therapist.

Self-help groups

Self-help organizations, run by clients of the mental health system and their families, provide an important part of treatment for people with mental illness and their families. Self-help groups offer the chance to meet informally with other people who understand the same issues and

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challenges. These groups can reduce a sense of isolation and provide opportunities to learn from other group members' experiences. Volunteering and sharing the wisdom gained by living with mental illness can be an empowering experience for others.

Family support and involvement

Informal relationships with friends, family, co-workers and others play a vital role in supporting and maintaining mental health. Family members and friends of people with mental illness need as much information as possible so they can assist and support their loved ones, and deal with their own feelings.

Community support

People with serious mental illness need access to social services, education, public housing, social support and family services to maintain wellness. In addition to these services, there are networks of community groups and organizations that contribute to community life. Interest-based groups (such as gardening and sports clubs), religious organizations and service clubs (such as Kiwanis and Rotary) also provide the opportunity for meaningful involvement in the community.

> Activity 4: Auditory hallucinations

PURPOSE: To get students to experience the fear, frustration and confusion of auditory hallucinations.

MATERIALS: two photocopies of Handout 2 — "Voices" Script.

TIME: About 20 minutes, including the discussion that follows the activity.

NOTE: This particular exercise has been criticized by some people with mental illness as not being a good representation of what auditory hallucinations are really like. If you decide to do this activity, indicate that it is very difficult to truly feel what it is like to experience auditory hallucinations and that every person will experience them in a slightly different way.

INSTRUCTIONS: Tell students you will be taking them through an exercise that attempts to show them what it is like to experience auditory hallucinations, or hearing voices. Ask for four volunteers from the audience. Ask each person in a group to take on one of the four following roles:

- a person with schizophrenia
- a friend
- voice 1
- voice 2.

The people playing voice 1 and voice 2 get a copy of Handout 2 — "Voices" Script and stand on

either side of the student playing the role of the person with schizophrenia. The person playing the "friend" stands across from the "person with schizophrenia." Tell the people who are playing the "friend" and the "person with schizophrenia" to talk to each other about anything — school, what they did that weekend, anything. Tell the people playing the "voices" to read their script to the "person with schizophrenia" at the same time. They should do this quietly but loud enough to be heard by the "person with schizophrenia."

Once you tell the volunteers to begin, let the activity continue for a minute or so. It will probably get very noisy and there will be lots of laughing, but students enjoy this activity and do get the point of the exercise.

Once you've asked them to stop the exercise and they've settled back into their seats, ask them the following questions:

1) What was it like for those of you who were playing the part of the person with schizophrenia?

Typical answers are: confusing, frustrating, hard to focus on what the "friend" was saying, couldn't carry on the conversation, etc.

2) What was it like for those of you who were playing the part of the friend?

Typical answers are: frustrating, the other person wasn't answering their questions.

3) What were some of the things the voices were saying?

The main points are that voices aren't always commanding and that sometimes there are themes to the voices; they can be religious or sexual or punitive and sometimes they don't mean anything.

4) What do you think it would be like to be in a class at school or in a job interview or taking an exam while experiencing auditory hallucinations?

Typical answers include: distracting, hard to concentrate, hard to do well.

"VOICES" SCRIPT

VOICE 1

You jerk!
Stupid!
Everyone knows it

They're all looking at you
They know you're stupid

They are laughing at you
You're ugly
Hide your face
Run away

You're no good
You lazy, good for nothing

Get a job you bum
Do something
Don't listen to them

Go for a coffee
Have a cigarette
This is boring

Hurt yourself
You deserve it
You're useless
No one cares

VOICE 2

Save these people
They're devils
They must be persecuted

God works through you
You can save the world
You are Jesus, son of God

Cleanse yourself
Save the world
Dirty! Dirty!

Take your clothes off
Purify yourself
Go naked in the presence of God
Naughty! Naughty!

You're tired
Get out of here
Go to sleep

They're staring with evil eyes
Run away

Hit them now
Hit! Hit!
Before they hurt you

COMPONENT 3 — THE PRESENTATION

RATIONALE

Overwhelmingly, teachers and students identified the major strength of the awareness program as the opportunity to interact with people personally affected by mental illness. It provides a unique kind of experiential learning — one that breaks down barriers by bringing the community into the classroom. The presentation is a central component of the program; it helps to put a personal face on mental illness and reminds students that mental illness can happen to anyone.

Preparing for the presentation

Teachers play an important role in making the awareness presentation a positive learning experience for their students. Some simple activities before the presentation (see Components 1 and 2) will make students more comfortable with the subject and engage in meaningful dialogue with the presenters and one another. Following the presentation, teachers play an equally valuable role: they ask students how they felt about the presentation and respond to unanswered questions and issues, including local resources for mental health problems.

The following is a list of tips and recommendations for teachers whose students are going to participate in an awareness presentation. The ideas and suggestions are gathered from a survey and focus group conducted with teachers who participated in the program.

1) Make sure the right people are "in the know."

Ensure the principal and other appropriate personnel and staff members know about the awareness presentation.

2) Have support on hand.

Plan to have a guidance counsellor at the presentation or available afterwards for students' questions.

Consult with colleagues about students who may find the presentation sensitive because of difficulties they, or someone close to them, is having.

3) Find out about details of the presentation.

How long will it be?

How many presenters will there be?

What types of mental illness will presenters be talking about?

Will mental health professionals be involved in the presentation?

4) Arrange for an appropriate space.

The presentation will be most effective if presenters and students are comfortable. It's important to choose a space that is intimate, though not claustrophobic. Often, classrooms are an appropriate venue because they are the right size for a single class and tend to have fairly good acoustics.

You might want to use the school library or another larger space if more than one class is participating. Auditoriums are generally not appropriate. They are so large and formal, they may create a sense of distance between the presenters and the students.

Consider the set-up of the room. Presenters can form a panel at the front of the room or everyone can sit together in a circle.

5) Think ahead about welcoming and thanking participants.

Plan to have a student or teacher welcome the presenter and thank them after the presentation.

Send a thank you note to the presenters and organizers to let them know the students enjoyed the program and learned from their efforts.

Preparing your students

It is important to go over a few basic ground rules with students before the presentation takes place.

Remind students to use respectful language — terms like crazy, mental, psycho, and so on, are not acceptable.

It is important students respect presenters' and other student's privacy. That means respecting the confidentiality of people's personal stories by not discussing them outside the classroom.

Prepare students for different presentation styles. Presenters are sharing their experience, but may not be expert public speakers, or experts on different forms of mental illness. Remind students that presenters are representing their own perspective and that everyone has a very different experience. Tell students presenters will welcome their questions and truly appreciate their sensitivity and interest.

Ask students to phrase questions thoughtfully and reflect on presenters' experiences before they ask deeply personal questions. Tell students if they think a question might make a presenter uncomfortable, they could preface their question with a phrase such as "I'm not sure if you'll want to answer this, but..."

Prepare students for the emotional nature of some of what they may hear. Some discussions may evoke discomfort for some students, and may lead them to question their own functioning. Students need to know this is a natural reaction to the discussion. In the discussion, presenters should establish a clear distinction between distress and illness, and clearly define processes for seeking help.

Preparation checklist for teachers

BEFORE THE PRESENTATION:

- ☐ Prepare students in advance by covering material in classroom.
- ☐ Establish clear ground rules and expectations for students (e.g., respectful listening, privacy and confidentiality).

DURING THE PRESENTATION:

- ☐ Have a guidance counsellor, social worker, or school nurse present.
- ☐ Observe students' reactions to the material and the speakers.

AFTER THE PRESENTATION:

- ☐ Distribute the resource list of local mental health services and supports to students.
- ☐ Follow up with students who express concerns.

COMPONENT 4 — FOLLOW-UP ACTIVITIES AND RESOURCES

Rationale

Now that students have learned some facts about mental illness and have heard about the experiences of people with mental illness, they are ready to learn how to take action against stigma. The purpose of this section is to show students how to: change their own behaviour; help others learn about stigma and mental illness; be supportive to someone they know who has a mental illness; and how to find help for themselves if they think they have a mental health problem.

Although the presenters' stories reflect their individual experiences, the presentation often raises broader issues about the way society treats people with mental illness. Following up the presentation with discussion and additional information is an integral part of the learning process.

After listening to the presenters' personal stories, students are often eager to talk about what they can do to change the way people with mental illness are treated, and more generally, the way mental illness is viewed. The follow-up session provides an opportunity for students to identify their concerns and identify ways they can work to change attitudes and behaviours.

The follow-up is also important because some students respond emotionally to the presentation. The experiences of the presenters may prompt students to think about their own mental health and that of their family and friends. This may lead students to disclose a mental health problem or concern to the teacher, often in written work following the presentation.

It is a good idea to anticipate potential student disclosures and/or concerns, and to be prepared to deal properly with these situations. Teachers will need the support of school-based resources (such as guidance counsellors, social workers, nurses and chaplains), the organizing committee, as well as local mental health professionals, to ensure a student's confidentiality is respected and they are given support and information about where and how to get help.

Provide students with some general information on ways to get help. The organizing committee will give you a list of mental health resources available in your community. Ask committee members to distribute the list at the presentation. You can also let students know what resources are available within the school (e.g., guidance counsellors, school nurses, teachers).

Teachers can also take advantage of events in their school and community to encourage ongoing thoughtful discussion about mental health and mental illness. This can be an effective way of increasing students' knowledge about mental illness and their awareness that mental illness affects all members of society. Students may want to participate in some of these events, such as Mental Illness Awareness Week and Walk for Schizophrenia. Teachers can contact the organizing committee to find out how to get involved.

Overview of Educational Activities

1) Analysis of media coverage

2) Dos and don'ts brainstorm

3) Support strategies

4) Working and volunteering in mental health

5) Where to get help

6) Awareness posters

7) Class newsletter or magazine

Overheads and handouts needed

Overhead/Handout 9 — Support Strategies (handout copies optional)

Newspaper and magazine articles that discuss mental illness, or provide an account of an incident involving a person with mental illness. (see page 67 for details)

A list of local agencies and organizations that offer volunteer and career opportunities in the field of mental health. The program's local organizing committee will supply this list.

A copy of Where to Get Help; this information sheet will be provided by the organizing coalition in your community.

Educational activities: Descriptions, instructions and tools for Component 4

> Activity 1: Analysis of media coverage

PURPOSE: The purpose of this activity is to highlight the role media plays in influencing public understanding and perception of mental illness, and to help students evaluate media messages about mental illness.

MATERIALS: Collect articles from newspapers and magazines that discuss mental illness, or provide an account of an incident involving a person with mental illness. It is particularly effective if you can find coverage of the same story or event from different news sources. There are a number of resources available on the Internet on the Stigmabusting Web site, such as a sheet of statistics that highlights the prevalence of negative media depictions of people with mental illness (http://mason.gmu.edu/~owahl/MEDIA.HTM).

TIME: About 20 minutes

INSTRUCTIONS: Ask students to break off into small groups in order to analyze and compare the way each article depicts mental illness or people with mental illness. Ask them to find examples of stigmatizing or stereotypical images and language, and to think of alternative ways of reporting the story that would not perpetuate stereotypes of people with mental illness. Ask each group to share their discussions with other members of the class.

> Activity 2: Dos and don'ts brainstorm

PURPOSE: The purpose of this activity is to encourage students to think about taking steps toward changing their language and behaviour and promoting a more accepting community.

MATERIALS: The Dos and Don'ts Suggestion List located on the next page.

TIME: About 5 minutes.

INSTRUCTIONS: Ask students to brainstorm ideas about ways of talking about, and behaving toward, people with mental illness that are inappropriate, stigmatizing and disempowering. Ask them to come up with a list of suggestions for more respectful language and behaviour and ways of raising awareness about the issue of stigma in the school and the community. If students need some hints, use the suggestions provided.

Make links to the personal experiences of consumer-survivors and/or responses from the free association exercise done before the presentation.

DOS AND DON'TS SUGGESTION LIST

Disempowering language	Empowering language
"the mentally ill"	consumer
victims, suffering	survivor
crazy, wacko, lunatic, psycho, psychopath, demented	people/person with mental illness

Disrespectful language	Respectful language
schizophrenic	person with schizophrenia
manic depressive	person with bipolar disorder
handicapped person	
slow	
retarded	
challenged	
special	
normal vs. not normal	

Don't	Do
refer to people by their illness	put the person first
talk about people	talk with people
be judgmental	become informed about mental illness
	take action in your community and school, e.g. Walk for Schizophrenia

> Activity 3: Support strategies

PURPOSE: The purpose of this discussion is to provide students with strategies for supporting people with mental illness.

MATERIALS: Overhead/Handout 9 — Support Strategies, overhead projector, and enough photocopies for each student (optional).

TIME: About 5 minutes.

INSTRUCTIONS: Ask students to think about how they would hope to be treated if they had a mental illness. Ask for some suggestions. Use the overhead as a starting point to encourage further discussion.

SUPPORT STRATEGIES

Here are some strategies for supporting someone with a mental health problem:

- Be supportive and understanding.
- Spend time with the person. Listen to him or her.
- Never underestimate the person's abilities.
- Encourage the person to follow his or her treatment plan and seek out support services.
- Become informed about mental illness.
- If you are a close friend or family member of someone who has a mental illness, make sure you get support as well. Crisis training, self-help and/or individual counselling will help you become a better support person.
- Put the person's life before your friendship. If you think the person needs help, especially if she or he mentions having thoughts of suicide, don't keep it a secret (even if the person may have asked you to). Tell his or her parents or someone else who can help.

> Activity 4: Working and volunteering in mental health

PURPOSE: Provide students with a list of local agencies and organizations that offer volunteer and career opportunities in the field of mental health. The program's local organizing committee will supply this list.

MATERIALS AND INSTRUCTIONS: Provide students with lists of mental health careers and volunteer opportunities.

> Activity 5: Where to get help

MATERIALS AND INSTRUCTIONS: Provide students with a list of resources available in your community. A template for creating this list is found in the accompanying *Community Guide*. The list may be provided by the organizing coalition in your community. This list should include phone numbers and addresses and explain what each organization offers. It will be important to tell students that all services are private.

You can also highlight resources present within the school such as guidance counsellors, school nurses, chaplains and social workers, as well as other possible resources in the community, such as hospitals, clergy and family doctors.

> Activity 6: Awareness posters

PURPOSE: To engage the students in a creative response to combating stigma in their school and community.

MATERIALS: Posterboard, newspapers, magazines, paints, glue and other art supplies.

TIME: 30–60 minutes. Could be assigned as homework.

INSTRUCTIONS: Ask students to design a poster that will create awareness about a mental health issue. Possible issues include: the impact of stigma on the lives of people with mental illness; facts about a particular mental illness; the important contributions of people with mental illness; stereotypes of people with mental illness, etc. Ask students to make the posters large, colourful and appealing. Display the posters prominently in different areas of the school.

> Activity 7: Class newsletter or magazine

PURPOSE: To share students' impressions of the program with other members of the school community.

MATERIALS: Computers, magazines and newspapers, students' written perspectives on the program, and/or poetry and artwork created by students in response to the program.

TIME: An ongoing group activity.

INSTRUCTIONS: Ask students to put together a magazine/newsletter about the program. Students can write a short column or report to contribute, or can work on developing graphics, artwork, layout, etc. The finished product can be assembled and given a catchy title and an attractive cover. The newsletter can be reproduced and copies can be distributed to different classrooms and common areas throughout the school.

SECTION 3: EVALUATION OF THE PROGRAM

Why evaluate?

Since you and everyone involved in Talking About Mental Illness put a lot of time and effort into organizing and implementing the program, you probably want to know how well it worked. Did the students learn anything? How did the program affect their knowledge and attitudes? What did they particularly like or dislike about the experience? What would you change if you were to do it again?

Past evaluations: Summary and results

Evaluations were conducted of both the original Beyond the Cuckoo's Nest program at the Clarke Institute of Psychiatry and later of the CAMH and partner programs in the three communities. These evaluations used questionnaires to measure students' knowledge about mental illness, as well as their attitudes toward people with mental illness before and after the presentation (pre- and post-test). Following the presentation, students were also asked to rate the presentation and were given a chance to answer some open-ended questions about what they liked and disliked.

Summary

In the spring of 2000, 278 students from eight secondary schools in the three pilot communities completed evaluation questionnaires. In all cases, school personnel implemented the evaluation. Students were surveyed before and after the presentation in some schools, and only after in others.

The pre-test measured students' knowledge about mental illness and their attitudes toward mental illness and people with mental illness. The post-test, measured the same variables as the pre-test to determine if there had been any changes. Students were also asked to rate the presentation and to comment about what they liked and disliked.

Results

In almost all cases, knowledge scores increased significantly following the presentation. Attitudes tended to become more positive toward people with mental illness at the post-test, but the change was not as great as for knowledge. This result is consistent with what is known about the difficulty of changing attitudes in a short period of time, and following a single intervention.

In the Comments section, students most often wrote that the most important parts of the presentation were the opportunities to hear people tell their own stories and to have their own questions answered. Following are some typical comments about what the students liked best about the presentation:

- It wasn't just people talking about something they never experienced, it was real people with real stories.
- I was able to hear different stories and the speakers were very open and answered our questions.
- I think that the stories were touching and they made me realize mental illness is as serious as physical illness.
- The interviews — because it helped me to understand how people with mental illness cope with their condition.
- Talking with the person who had experienced a mental illness and their family members.

Comments were less consistent about what students disliked, depending on the make-up of the presentation they attended. Following are some examples:

- I think with people my age they should have talked more about eating disorders and how we could prevent them.
- The presenters should have talked longer and should have had more question time.
- I didn't like the fact that the presenters read the information on the overheads instead of explaining it.

· Three people came in to talk about the same disorder (bipolar disorder).

How much evaluation should you undertake?

You decide how much evaluation to undertake. If you decide to use the pre- and post-tests, it's best if the pre-test be conducted approximately one week before any of the preparatory learning activities and under teacher supervision. It is important to complete the post-test within a week or two of the presentation, after the follow-up activities.

Let students know that, although the final results of the evaluation will be confidential (no names will be attached to their comments), it is important to have completed the identifying information on the top of the pre and post student questionnaires. It will make it possible to match students' responses and compare them before and after the presentation. If you need help administering the evaluation, contact members of the organizing committee. They will help you carry out the evaluation effectively and summarize the results.

Making evaluation a success

As the program gains popularity, the results of the evaluations can be helpful in encouraging other teachers and schools to consider hosting the program. Schools may be more willing to host the program when they learn other students benefited from having participated.

Teachers' responses can also help open up new opportunities for the program because teachers like to hear how other teachers incorporated the program into their courses and what their overall impressions were. The following are some tips for ensuring your evaluation goes smoothly and proves to be useful.

· Create enthusiasm by reminding students their responses will have a direct influence on the program's development, and that they can help improve the program for the future.

· Make sure to communicate the results of the program evaluation to everyone who participated in the program. Students, presenters and organizers will appreciate hearing about the outcomes; they will feel their investment of time was worthwhile.

· Make good use of the results by creating a summary of the key findings, including written comments. Don't ignore the critical comments. They can be essential to improving the program.

· Feedback does not only happen through formal evaluations. Comments received from teachers and students can be equally valuable.

Evaluation tools

On the following pages, you will find three evaluation forms: a student pre-test, a student post-test, and a teacher evaluation form. Please photocopy as many as you will need to distribute to the students and teachers.

Talking about Mental Illness

STUDENT EVALUATION — PRE-TEST

Today's Date: _____ School: _____

Teacher's Name: _____ Subject: _____

Female ☐ or Male ☐ Birth date: Day _____ Month _____ Year _____ Grade: _____

A. Please indicate how much you feel you **KNOW** about each of the following. Circle the number that best describes your knowledge.

	None	A little	Some	A lot
1. mental illness in general	1	2	3	4
2. how people cope with mental illness	1	2	3	4
3. different approaches to help persons with mental illness	1	2	3	4
4. what it is like to have a mental illness	1	2	3	4
5. what it is like to have a family member with mental illness	1	2	3	4
6. the causes of different forms of mental illness	1	2	3	4
7. how to recognize signs of mental illness	1	2	3	4
8. different training and career paths mental health workers have	1	2	3	4

B. Please indicate how much you agree or disagree with the following statements by circling the appropriate number.

	Strongly disagree	Disagree	Agree	Strongly agree
1. Most people with a serious mental illness can, with treatment, get well and return to productive lives.	1	2	3	4
2. In most cases, keeping up a normal life in the community helps a person with mental illness get better.	1	2	3	4

	Strongly disagree	Disagree	Agree	Strongly agree
3. People with mental illness are far less of a danger than most people believe.	1	2	3	4
4. Locating a group home or apartments for people with mental illness in residential neighbourhoods does not endanger local residents.	1	2	3	4
5. Locating a group home or apartments for people with mental illness in a residential area will not lower the value of surrounding homes.	1	2	3	4
6. People with mental illness are, by far, more dangerous than the general population.	1	2	3	4
7. Mental health facilities should be kept out of residential neighbourhoods.	1	2	3	4
8. Even if they seem OK, people with mental illness always have the potential to commit violent acts.	1	2	3	4
9. It is easy to recognize someone who once had a serious mental illness.	1	2	3	4
10. The best way to handle people with mental illness is to keep them behind locked doors.	1	2	3	4

THANK YOU

Talking about Mental Illness

STUDENT EVALUATION — POST-TEST

Today's Date: _____ School: _____

Teacher's Name: _____ Subject: _____

Female ☐ or Male ☐ Birth date: Day _____ Month _____ Year _____ Grade: _____

A. Please indicate how much you feel you **KNOW** about each of the following. Circle the number that best describes your knowledge.

	None	A little	Some	A lot
1. mental illness in general	1	2	3	4
2. how people cope with mental illness	1	2	3	4
3. different approaches to help persons with mental illness	1	2	3	4
4. what it is like to have a mental illness	1	2	3	4
5. what it is like to have a family member with mental illness	1	2	3	4
6. the causes of different forms of mental illness	1	2	3	4
7. how to recognize signs of mental illness	1	2	3	4
8. different training and career paths mental health workers have	1	2	3	4

B. Please indicate how much you agree or disagree with the following statements by circling the appropriate number.

	Strongly disagree	Disagree	Agree	Strongly agree
1. Most people with a serious mental illness can, with treatment, get well and return to productive lives.	1	2	3	4
2. In most cases, keeping up a normal life in the community helps a person with mental illness get better.	1	2	3	4

	Strongly disagree	Disagree	Agree	Strongly agree
3. People with mental illness are far less of a danger than most people believe.	1	2	3	4
4. Locating a group home or apartments for people with mental illness in residential neighbourhoods does not endanger local residents.	1	2	3	4
5. Locating a group home or apartments for people with mental illness in a residential area will not lower the value of surrounding homes.	1	2	3	4
6. People with mental illness are, by far, more dangerous than the general population.	1	2	3	4
7. Mental health facilities should be kept out of residential neighbourhoods.	1	2	3	4
8. Even if they seem OK, people with mental illness always have the potential to commit violent acts.	1	2	3	4
9. It is easy to recognize someone who once had a serious mental illness.	1	2	3	4
10. The best way to handle people with mental illness is to keep them behind locked doors.	1	2	3	4

C. As a result of participating in the program, please indicate how much you agree or disagree with the following statements.

	Strongly disagree	Disagree	Agree	Strongly agree
1. The classroom activities and presentations held my attention.	1	2	3	4
2. I learned a lot from the presentations.	1	2	3	4
3. The presentations are a good way to learn about mental illness.	1	2	3	4
4. It is valuable for students to be able to ask presenters questions.	1	2	3	4

	Strongly disagree	Disagree	Agree	Strongly agree
5. The experience of the presenters was relevant to people my age.	1	2	3	4
6. I learned some new information about mental illness.	1	2	3	4
7. I feel better about my ability to talk with someone with mental illness.	1	2	3	4
8. I feel that I know more about the emotions experienced by someone who has a mental illness.	1	2	3	4
9. In the future, I will feel more comfortable when I meet people with mental illness.	1	2	3	4
10. I would recommend this program to a friend who hasn't participated in it.	1	2	3	4

D.

1. What I liked **MOST** about the program was:

_____

_____

_____

2. What I liked **LEAST** about the program was:

_____

_____

_____

3. If you have any further comments on the program or would like to make suggestions for the improvement of the program, please add them below.

_____

_____

_____

THANK YOU

Talking about Mental Illness

TEACHER EVALUATION

We would appreciate your help in evaluating the Talking About Mental Illness program. Your feedback will help us to improve it for the future.

Today's Date: _____ Grade: _____

School: _____ Name: _____

Date of Program: _____

1. (a) Please name the students' courses that the Talking about Mental Illness program is being incorporated into:

   _____

   (b) Approximately how much time was devoted to the suggested classroom activities **PRIOR TO** the presentation?

   _____ hours

   (c) Approximately how much time did you spend **AFTER** the presentation debriefing?

   _____ hours

   Please describe:

   _____

2. How helpful did you find the classroom activities contained in the *Teacher's Resource*?

   Not at all helpful 1 2 3 4 5 Very helpful

   Please list which activities you used:

   _____

3. In your experience, how closely did the suggested classroom activities complement the curriculum guidelines for your course?

   Not at all 1 2 3 4 5 Very

4. (a) What did you hope your students would learn from participating in the program?

_____

_____

(b) To what extent were your expectations satisfied?

Not at all 1 2 3 4 5 To a great extent

_____

_____

5. Do you feel the choice of presenters (e.g., person with mental illness, family) was appropriate?
Yes ☐ No ☐
Please comment:

_____

_____

6. Do you feel that the classroom setting was appropriate for the presentation?
Yes ☐ No ☐
Please explain:

_____

_____

7. Please make comments and suggestions on the presentation you attended (i.e., length, depth, format, content, etc.).

_____

_____

_____

_____

8. What other tools or activities would you like to see included in the *Teacher's Resource*?

_____

_____

_____

9. Overall, how would you rate the program?

1	2	3	4	5
Excellent	Very good	Good	Satisfactory	Unsatisfactory

10. Any additional comments or suggestions?

_____

_____

_____

_____

THANK YOU

APPENDIX A: ONTARIO MINISTRY OF EDUCATION AND TRAINING CURRICULUM GUIDELINES — MENTAL HEALTH

The following are excerpts from the Ontario Ministry of Education and Training's Curriculum Guidelines showing where mental health issues fit. Opportunities to address mental health/mental illness topics are indicated in bold.

1) Healthy Active Living Education (Grade 11)

The Grade 11 course Healthy Active Living Education is organized around four strands: 1) Physical Activity, 2) Active Living, 3) Healthy Living and 4) Living Skills, which are divided into units.

Within strand 3, Healthy Living, the guidelines for Healthy Active Living Education (Grade 11) specify the following overall expectations:

By the end of this course, students will:

- demonstrate an understanding of sexual and reproductive health
- demonstrate, in a variety of settings, the knowledge and skills that reduce risk to personal safety

- describe the influences of mental health on overall well-being.

Specific expectations for the unit on mental health, contained within strand 3 include:

By the end of this course, students will:

- describe the characteristics of an emotionally healthy person (e.g., positive self-concept, ability to manage stress effectively, ability to work productively)
- demonstrate the skills that enhance personal mental health (e.g., coping strategies for stress management)
- analyze the factors (e.g., environmental, genetic) that influence the mental health of individuals and lead to the prevalence of mental health problems in the community
- describe the impact of mental health disorders (e.g., phobias, anxiety disorder, schizophrenia, affective disorders) on a person's emotional and physical health
- identify and describe suicidal behaviours and strategies for suicide prevention.

Within strand 4, Living Skills, the guidelines for Healthy Active Living Education (Grade 11) specify the following overall expectations:

By the end of the course, students will:

- use decision-making and goal-setting skills to promote healthy active living
- demonstrate an ability to use stress management techniques
- demonstrate the social skills required to work effectively in groups and develop positive relationships with their peers.

Specific expectations for the unit Stress Management, contained in strand 4, include:

By the end of this course, students will:

- describe the positive and negative effects of stresses that are part of daily life
- explain physiological responses to stress
- use appropriate strategies for coping with stress and anxiety (e.g., relaxation, meditation, exercise, reframing)
- demonstrate an understanding of change and its impact on an individual's health.

2) Health for Life (Grade 11)

The Grade 11 course, Health for Life, is organized around three broad curriculum areas or strands: 1) Determinants of Health, 2) Community Health and 3) Vitality. These strands are divided into units. Mental health fits well into strand 1, Determinants of Health.

Within strand 1, Determinants of Health, the curriculum guidelines for Health for Life (Grade 11) specify the following overall expectations:

By the end of this course, students will:

- analyze the role of individual responsibility in enhancing personal health

- analyze the social factors that influence personal health.

Specific expectations for the unit Personal Factors, contained in strand 1, are:

By the end of this course, students will:

- **describe the interrelationship of physical, social, and mental health in enhancing personal health**
- **describe the heredity factors that influence personal health (e.g., a family history of an illness such as diabetes, breast cancer, cardiovascular disease, or mental illness; body shape and size)**
- analyze how various lifestyle choices (e.g., decisions pertaining to nutrition, physical activity, and smoking) affect health
- **evaluate the factors (e.g., personal responsibility; the influence of peers, culture, and the media) that influence personal choices with regard to health-related products and services**
- **explain how stress and one's ability to cope with stress affect personal health**
- **implement a personal plan for healthy living.**

Specific expectations for the unit Social Factors, contained in strand 1, are:

By the end of this course, students will:

- **describe how family, peers, and community influence personal health;**
- **analyze the social factors that influence personal health (e.g., employment, education, socio-economic status, isolation, rural and urban settings, access to health and recreational services);**
- **describe the influence of culture on health (e.g., foods eaten, methods of treating illness, gender roles).**

3) Introduction to Anthropology, Psychology and Sociology (Grade 11)

The Grade 11 course Introduction to Anthropology, Psychology and Sociology is organized around four broad curriculum areas or strands: 1) Self and Others, 2) Social Structures and Institutions, 3) Social Organization, and 4) Research and Inquiry Skills. These strands are divided into units. Mental health issues fit well into strands 1, Self and Others and 3, Social Organization.

Within strand 1, Self and Others, the overall expectations for Introduction to Anthropology, Psychology and Sociology (Grade 11) are:

By the end of this course, students will:

- describe some differences and similarities in the approaches taken by anthropology, psychology, and sociology to the concept of self in relation to others
- **demonstrate an understanding of the social forces that influence and shape**

behaviour as described by anthropologists, psychologists, and sociologists

- analyze socialization patterns from the perspectives of anthropology, psychology, and sociology.

Specific expectations for the unit Forces that Influence and Shape Behaviour, contained in strand 1, are:

By the end of this course, students will:

- **identify and assess the major influences that contribute to an individual's personal and social development (e.g., heredity, environment, race, gender)**
- **analyze the role of the mass media in influencing individual and group behaviour**
- explain why behaviour varies, depending on context and on the individuals involved (e.g., at work, within a family, in sports, in a crowd, in a large city or small town).

Specific expectations for the unit Socialization, contained in strand 1, are:

By the end of this course, students will:

- **explain the role of socialization in the development of the individual**
- **identify the primary and secondary agents of socialization (e.g., family, school, peers, media, work) and evaluate their influence**
- **demonstrate an understanding of anthropological, psychological, and sociological theories that deal with socialization (e.g., enculturation, nature versus nurture, social isolation)**
- **evaluate the role of cultural influences in socialization (e.g., as they affect gender expectations).**

Within strand 3, Social Organization, the overall expectations for Introduction to Anthropology, Psychology and Sociology (Grade 11) are:

By the end of this course, students will:

- demonstrate an understanding of the characteristics of groups in Canadian Society as identified by anthropology, psychology, and sociology
- **analyze the psychological impact of group cohesion and group conflict on individuals, groups, and communities**
- describe the characteristics of bureaucratic organizations.

Specific expectations for the unit: Conflict and Cohesion, contained in strand 3, are:

By the end of this course, students will:

- identify and compare anthropological, psychological, and sociological perspectives on conflict among individuals, groups, and communities
- analyze anthropological, psychological, and sociological perspectives on group cohesion
- **demonstrate an understanding of discrimination and exclusion in social relationships, from the perspectives of anthropology, psychology, and sociology**

- **analyze examples of social or institutional practices in earlier historical periods that formed the basis for social relationships involving discrimination or exclusion in contemporary society (e.g., apartheid, segregation, ghettoization, ostracism, gender discrimination).**

4) Media Studies (Grade 11)

The Grade 11 course, Media Studies, is organized around three broad curriculum areas or strands: 1) Media Texts, 2) Media Audiences and 3) Media Production.

Within strand 1, Media Texts, the guidelines for Media Studies (Grade 11) specify the following overall expectations:

By the end of the course, students will;

- **analyze, interpret, and assess the techniques, forms, style, and language of media works to describe and explain how different media communicate meaning;**
- **analyze media representations to describe their content, identify bias, and explain their impact on audiences.**

Specific expectations for the unit, Analyzing Media Forms, Techniques, Style and Language, contained in strand 1, include:

By the end of this course, students will:

- **identify the characteristics of a variety of media, including television, newspapers, and the Internet, and explain how these characteristics influence meaning (e.g., in an oral presentation examine how a newspaper, a radio station, a television network, and a news Web site cover the same event, and explain how the differences affect interpretations of the event);**
- **identify and explain how media conventions and techniques influence the creation and interpretation of media works (e.g., describe how audience expectations about a western or a horror film are shaped by the use of a familiar formula; compare the production costs for a 30-second TV commercial and a 30-minute TV show and assess the implications of the findings; report on the controversy about the use of computer retouching in fashion photography and photo-journalism);**
- **analyze how the language used in media works influences the interpretation of messages, with a focus on tone, level of language, and point of view (e.g., analyze the language used in a sports broadcast and explain its purpose and effect; describe the narrative language used in an animated media work and state what themes and beliefs are being communicated);**
- explain how a media form changes when presented in a new communication context and assess the effect of the changes (e.g., describe the changes that occur when newspapers

are presented on the Internet);

- explain the ways in which media influence and shape various environments and activities (e.g., describe how the televising of hockey or baseball games influences the appearance of the arena or stadium and the pace of the game).

Specific expectations for the unit, Analyzing Media Representations, contained in strand 1, include:

By the end of this course, students will:

- **analyze how individuals or groups are presented in media works and assess the accuracy and influence of these representations (e.g., create a collage of familiar stereotypes in the media and explain the overall impact of these images; compare media representations of work, vacation experiences, or family life with their own experiences;**
- **examine how people or groups are presented in a variety of media works and explain the beliefs revealed and the messages conveyed (e.g., discuss how the message of a popular television program would change if the main characters were from a different socio-economic or ethnic group; explain the effects of the inclusion, exclusion, or positioning of people or groups in magazine advertisements);**
- **analyze media representations of social, political, and cultural issues and explain how the presentations influence people's interpretation of the issues and their level of concern (e.g., analyze media coverage of the international response to a war or uprising; assess the effectiveness of public-service announcements in the media);**
- **analyze and explain the representations of behaviours and attitudes in media works (e.g., analyze the news coverage given to the achievements of a local hero; describe and explain the attitudes depicted during a conflict and its resolution in a feature or television drama);**
- **compare and analyze the representations of people and issues in a variety of media and identify factors that may account for any differences (e.g., compare the coverage of social issues and current events in mainstream media with that in alternative periodicals, video documentaries, or on some specialty cable-TV channels; prepare an oral presentation about how the ownership of a variety of media may influence their presentation of events).**

5) Leadership and Peer Support (Grade 11)

The Grade 11 course, Leadership and Peer Support, is organized around three broad curriculum areas or strands: 1) Personal Knowledge and Management Skills; 2) Interpersonal Knowledge and Skills; and 3) Exploration of Opportunities.

Within strand 2, Interpersonal Knowledge and Skills, the guidelines for Leadership and Peer

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Support (Grade 11) specify the following overall expectations:

By the end of this course, students will:

- **demonstrate an understanding of and use theories and strategies related to positive and healthy interpersonal relationships;**
- demonstrate an understanding of and use theories and strategies related to effective communication;
- **demonstrate an understanding of theories and strategies related to leadership and group dynamics and use these to help individuals and diverse groups achieve their goals;**
- **demonstrate an understanding of how community diversity and individual rights and responsibilities affect leadership and peer support roles.**

Specific expectations for the unit on Interpersonal Relations, contained in strand 2, include:

By the end of this course, students will:

- demonstrate an understanding of the characteristics of positive relationships and of the early signs of an abusive relationship;
- **demonstrate an understanding of the elements of good mental health;**
- **describe the elements of effective interpersonal relations (e.g., respect for differences; flexibility, honesty, integrity) and demonstrate their use in selected leadership and peer support roles in the school or community;**
- describe a conflict resolution model and demonstrate its use in a variety of situations to reduce conflict and reach mutually agreeable solutions;
- **define and explain concepts (e.g., bias, stereotyping, prejudice) and contemporary social problems (e.g., substance abuse, poverty, violence) that denote barriers to individual success, and identify strategies to address these barriers;**
- **identify the types and sources of pressure on adolescents (e.g., peer pressure, family tensions, media influence), describe the behaviours that may result, and identify appropriate strategies to deal with pressure.**

Specific expectations for the unit on Communication Skills, contained in strand 2, include:

By the end of this course, students will:

- **explain the benefits and pitfalls of expressing emotions and demonstrate appropriate ways of managing their own emotions;**
- **describe the elements of effective communication (e.g., active listening, non-judgmental statements, paraphrasing) and demonstrate their use in selected leadership and peer support roles in the school or community (e.g., tutoring, mentoring, coaching, mediating, assisting with school or community projects);**
- **use feedback effectively and appropriately to help others identify their strengths and areas needing improvement;**

- **demonstrate an understanding of how to respond appropriately to peers' disclosures of serious personal matters (e.g., health problems, physical and emotional abuse, family issues, harassment, substance abuse).**

Specific expectations for the unit on Connecting With the Community, contained in strand 2, include:

By the end of this course, students will:

- **describe the dimensions of diversity within their community (e.g., gender, culture, race, ability, age, religion, socioeconomic level) and identify the value of diversity as well as the challenges it poses;**
- **describe their rights and responsibilities as a part of a community whose members come from diverse backgrounds;**
- identify their own rights and responsibilities and those of others that influence the ways they perform various leadership and peer support roles;
- **explain how power can be used positively or misused in work, family, and peer contexts and identify strategies to deal with situations where power is misused (e.g., gang aggression, child abuse, workplace harassment);**
- **describe the causes and costs to individuals, families, and communities of discrimination, harassment, violence, and poverty, using appropriate documentation and statistical information;**
- **describe a personal vision of a just equitable society and propose means of addressing social and individual problems.**

6) Philosophy: The Big Questions (Grade 11)

The Grade 11 course Philosophy: The Big Questions is organized around four broad curriculum areas or strands: 1) Philosophical Questions, 2) Philosophical Theories, 3) Philosophy and Everyday Life, and 4) Applications of Philosophy to Other Subjects. Mental health issues fit well into strand 3, Philosophy and Everyday Life.

Within strand 3, Philosophy and Everyday Life, the overall expectations for Philosophy: The Big Questions are:

By the end of this course, students will:

- **relate the big questions of philosophy to their own experience, reports in the news media, and their society;**
- demonstrate the application of philosophical theories and skills to jobs, occupations, and everyday life.

Specific expectations for strand 3, Philosophy and Everyday Life are:

By the end of this course, students will:

- describe what difference the answers people accept to three (or more) of the big questions of philosophy should make to their values, behaviour, and life plans;
- **describe the strengths and weaknesses of alternative responses to questions of applied philosophy (e.g., What decisions, if any, should medical practitioners make for patients without the patient's consent?; What obligations, if any, do humans living in the present have to future generations and to the natural environment?; What obligations, if any, do humans living in the present have to redress racial or gender inequalities inherited from the past?);**
- apply philosophical skills such as precise writing and critical analysis to solve problems that arise in jobs and occupations (e.g., What obligations do employees have to the public, to their employers, and to themselves?; When resources are scarce, how should decisions be made about their allocation?).

7) Individuals and Families in a Diverse Society (Grade 12)

The Grade 12 course, Individuals and Families in a Diverse Society, is organized around five broad curriculum areas or strands: 1) Self and Others, 2) Personal and Social Responsibilities, 3) Diversity, Independence, Global Connections, 4) Social Challenges and Social Structures, and 5) Research and Inquiry Skills.

Within strand 4, Social Challenges and Social Structures, the guidelines for Individuals and Families in a Diverse Society (Grade 12) specify the following overall expectations:

By the end of this course, students will:

- analyze current issues and trends relevant to individual development, and speculate on future directions;
- analyze current issues and trends affecting the dynamics of intimate relationships, and speculate on future directions for individuals and families;
- analyze current issues and trends affecting childrearing and socialization and speculate on the changing role of children;
- demonstrate an understanding of the cycle of violence and consequences of abuse and violence in interpersonal and family relationships.

Specific expectations for the unit, Individual Development, contained in strand 4, include:

- **describe current perceptions, opinions, and demographic trends relating to the life patterns of individuals (e.g., life expectancy, educational attainment, labour-force participation, income), and speculate on the significance of these trends for individual development;**
- **explain the impact on individual development and decision making of social changes and challenges (e.g., AIDS, emerging communication technologies, the increase in non-family households, cultural diversity) and life events (e.g., illness,**

infertility, disability, unemployment, death, divorce);

- **demonstrate an understanding of the effect of various aspects of social systems, on individual development (e.g. legal requirements, such as age restrictions; economic factors; educational opportunities; employment trends; availability of social support).**

8) Healthy Active Living Education (Grade 12)

The Grade 12 course, Healthy Active Living Education, is organized around four broad curriculum areas or strands: 1) Physical Activity, 2) Healthy Living, 3) Active Living, and 4) Living Skills. These strands are divided into units.

Within strand 2, Healthy Living, the guidelines for Healthy Active Living (Grade 12) specify the following overall expectations:

By the end of this course, students will:

- describe how society and culture affect individual perceptions and expressions of sexuality;
- demonstrate an understanding of strategies that promote personal safety and prevent injuries;
- demonstrate an ability to use specific strategies to enhance their own mental health and that of others;
- **demonstrate an understanding of strategies that promote healthy relationships.**

Specific expectations for the unit on mental health, contained in strand 2, include:

By the end of this course, students will:

- **demonstrate an understanding of specific mental health issues (e.g., depression, anxiety, suicide);**
- **apply the skills necessary to manage stressful situations (e.g., death and dying; mental or physical illness in a family);**
- **demonstrate an ability to use skills to enhance their own mental health;**
- **describe the importance of relationships and communication with others to mental health;**
- **identify sources of information on and services related to mental health (e.g., the Internet, libraries, community agencies, and media) in the community and beyond.**

9) Challenge and Change in Society (Grade 12)

The Grade 12 course, Challenge and Change in Society, is organized around four broad curriculum areas or strands: 1) Social Change, 2) Social Trends, 3) Social Challenges, and 4) Research and Inquiry Skills. These strands are divided into units. The strand in which mental health fits well is Social Challenges.

Within strand 3, Social Challenges, the curriculum guidelines for Challenge and Change in Society specify the following overall expectations:

By the end of this course, students will:

- appraise the differences and similarities in the approaches taken by anthropology, psychology, and sociology to the study of social challenges pertaining to health, social injustice, and global concerns;
- demonstrate an understanding of the social forces that shape such challenges.

Specific expectations for the unit Health and Wellness, contained in strand 3, are:

By the end of this course, students will:

- **analyze social practices leading to health-impairing behaviours from the perspective of at least two of anthropology (e.g., the impact of formula feeding over breast-feeding in developing countries), psychology (e.g., the increase of isolation and depression among the elderly), and sociology (e.g., the rise of smoking among teenaged girls);**
- **discuss cultural, psychological, and sociological barriers to accessing health care;**
- **demonstrate an understanding of the ethical issues related to health-care provision (e.g., the blood supply system, organ donation, medical research);**
- **evaluate the impact of changing social mores on the well-being of Canadians (e.g., desensitization to violence and abuse).**

Specific expectations for the unit, Prejudice and Discrimination, contained in strand 3, are:

By the end of this course, students will:

- **explain the relationship between prejudice and discrimination, and assess the impact of both on ideas of self-worth;**
- **assess the role of stereotyping as a barrier to full participation in society;**
- **analyze patterns of hate crimes and differentiate ways in which social scientists (e.g., John Ogbu, Gordon Allport, George Dei, Beverly Tatum, Stuart Hall) would attempt to understand racism.**

10) Parenting and Human Development (Grade 12)

The Grade 12 course, Parenting and Human Development, is organized around five broad curriculum areas or strands: 1) Stages of Family Life, 2) Human Development: Self and Others, 3) Personal and Social Responsibilities, 4) Social Structures and Social Challenges, and 5) Research and Inquiry Skills.

Within strand 4, Social Structures and Social Challenges, the guidelines for Parenting and Human Development (Grade 12) specify the following overall expectations:

By the end of this course, students will:

- analyze the challenges of balancing work and family;
- demonstrate an understanding of the role and functions of schooling in our society and in relation to family life;

- **evaluate the influence that the media have on parents, children, and adolescents;**
- **explain the role of social-service organizations in supporting children and families when problems arise.**

Specific expectations for the unit, Media Influence, contained in strand 4 include:

By the end of this course, students will:

- **demonstrate an understanding of the effects that media violence has on children and adolescents (e.g., increasing school and peer violence);**
- **analyze the influences advertising has on families (e.g., pressure to purchase fad items);**
- **analyze how families can adapt to focus on the positive uses of media (e.g., keeping abreast of current events through a discussion of daily new stories, by watching educational programming together).**

Specific expectations for the unit: The Role of Social Services, contained in strand 4, include:

By the end of this course, students will:

- **demonstrate an understanding of individual and family concerns (e.g., violence, poverty, family breakdown, addiction, death of a family member) that are addressed by agencies in society;**
- **identify the support and care options available to parents and siblings when a family member has a physical exceptionality or is affected by a disease or illness;**
- **explain the role and function of family counselling (e.g., short-term and crisis counselling, grief counselling, relationship counselling);**
- **identify job opportunities in the social-service sector that involve helping families.**

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APPENDIX B: USEFUL MENTAL HEALTH-RELATED WEB SITES

Mental health resources for educators

School Psychology Resources On-line: http://www.schoolpsychology.net

Study Web: Links for Learning: http://www.studyweb.com/science/ment_toc.htm

Teachers First — Guidance Issues, links to teens at risk: http://www.teachersfirst.com/guidance.htm

General mental health Web sites

Canadian Health Network: http://www.canadian-health-network.ca/1mental_health.html

Canadian Mental Health Association, National Office: http://www.cmha.ca/

Canadian Mental Health Association, Ontario Division: http://www.ontario.cmha.ca/

Centre for Addiction and Mental Health: http://www.camh.net

Internet Mental Health: http://www.mentalhealth.com

Health Canada, Mental Health Web site: http://www.hc-sc.gc.ca/hppb/mentalhealth/index.html

Mental Health Centre: http://www.health-center.com/english/brain/

National Alliance for the Mentally Ill: http://www.nami.org/

The Self-Help Resource Centre of Ontario: http://www.selfhelp.on.ca/

Children and youth

Bipolar Kids Homepage: http://www.bpkids.org

Breakaway — for youth and adults 13-25 years of age and their families, deals with concern about the use of alcohol and drugs. http://www.breakawayyouth.org

Adolescent depression and suicide

You asked about.... Adolescent depression — from the Internet Mental Health Web site http://www.mentalhealth.com/mag1/p51-dp01.html

The Befrienders: Youth depression and suicide: http://www.jaring.my/befrienders/youth1.htm

Eclipse Depression and Manic Depression Support Group: http://www.bfree.on.ca/comdir/medical/eclipse/index.htm

Facts about youth suicide: http://www.emh.org/acadia/su.htm

Focus Adolescent Services: Warning Signs, Information, Getting Help: http://www.focusas.com/Depression.html

Recognizing depression in youth: http://www.extension.unr.edu/teens/depression.html

Suicide Awareness Voices of Education: http://www.save.org/

Suicide Information and Education Centre: http://www.suicideinfo.ca/

Youthwork Links — Emotions and Behaviour — Suicide: http://www.youthwork.com/healthmentsuicide.html

Training on suicide prevention: http://www.livingworks.net

Anxiety disorders

Obsessive Compulsive Disorder home page: http://www.fairlite.com/ocd/

Obsessive-Compulsive Foundation: http://www.ocfoundation.org/

Anxiety Disorders Association of America: http://www.adaa.org/

Eating disorders

National Eating Disorder Information Centre: http://www.nedic.ca

Eating Disorders Awareness and Prevention (U.S.): http://www.edap.org

Bulimia Anorexia Nervosa Association: http://www.bana.ca

Information on Eating Disorders: http://members.aol.com/lacillo/eating.html

The Something Fishy Web site on Eating Disorders: http://www.sfwed.org/

Mood disorders

Mood Disorders Association of Ontario (MDAO): http://www3.sympatico.ca/mdmt

National Depressive and Manic Depressive Association: http://www/ndmda.org

Bipolar Disorder Information Centre: http://www.mhsource.com/bipolar/index.html

Dr. Ivan's Depression Central: http://www.psycom.net/depression.central.html

About Bipolar Disorder: http://bipolar.about.com/health/bipolar/

About Depression: http://depression.about.com/health/depression/

National Foundation for Depressive Illness: http://www.depression.org/

Wing of Madness Depression Community: http://www.wingofmadness.com/

Treatment of Bipolar Disorder: A guide for patients and families:
http://www.psychguides.com

Schizophrenia

Ian Chovil's Homepage: http://www.chovil.com/

Schizophrenia.com: http://www.schizophrenia.com/

Schizophrenia Society of Canada: http://www.schizophrenia.ca/

The World Psychiatric Association program to fight stigma due to schizophrenia:
http://www.openthedoors.com/

Schizophrenia Digest: http://www.schizophreniadigest.com/

Mental illness and the arts

Centre for Addiction and Mental Health — Images 2000 Exhibit:

http://www.camh.net/events/images_2000.html

Dee Rimbaud: http://www.writhe.net/rimbaud/frame.html

First Person: http://www.lstpm.org/

Fire and Reason: http://www.geocities.com/fire_reason/

The Reading Room: http://www.geocities.com/the_reading_room/index.html

National Art Exhibitions by the Mentally Ill: http://www.naemi.org/

Please note: Aside from our own sites, no endorsement of any of the above sites by the Centre for Addiction and Mental Health should be inferred.

APPENDIX C: RESOURCES FOR YOUTH (ALTERNATIVE FORMATS — CD-ROMS, 'ZINES, ON-LINE DISCUSSIONS)

Fire and Reason

http://www.geocities.com/fire_reason

A series of 'zines brings together powerful written and visual creative work by young people who struggle with depression or manic depression. The long-term goal is to publish an anthology. The aim of *Fire and Reason* is to create much-needed resources and raise awareness, while celebrating and sharing the insight and creativity of young Canadians.

Mauve

http://www.hc-sc.gc.ca/hppb/mentalhealth/mauve.htm

Teenagers take to the streets with video cameras in *Mauve*, an interactive CD-ROM created by and for youth today. They meet with other teens and talk about life and death, friendship and love, work and stress, and about themselves and the adults in their lives. These personal experiences are often humorous and sometimes troubling, but always true to life. Available through Health Canada, Mental Health Promotion.

Networking Youth Nationally

http://209.217.127.51/

This is a national network run by youth for youth that encourages young people to participate in problem solving and decision-making on mental health issues at individual and organizational levels. It also provides an opportunity for youth to support each other through life's ups and downs. The network strives to include all youth as well as people who care about and work with youth (such as youth-friendly professionals, educators, community workers, etc.).

For more information about Networking Youth Nationally (NYN) contact:

Tel: (613) 737-2764

Fax: (613) 738-3917

Students' Commission

http://www.tgmag.ca/aorg/

The Students' Commission is a global-minded organization that is run by youth for youth across Canada. The Commission is currently the lead organization for the National Centre of Excellence for Youth Engagement.

Working with its sister organization, Tiny Giant Magazine, the Students' Commission combines the expertise of multimedia and education professionals with diverse young people to create unique and highly effective programs for students.

Virtual Party Web Site

http://www.virtualparty.org

The Virtual Party is an interactive, educational Internet-based resource simulating a party situation, providing information to youth about alcohol, emphasizing healthy choices and imparting skills for the reduction of harm. It is targeted at youth between the ages of 13 and 19. The young person is able to choose either a male or female character, and make choices about their activities during a "virtual" event. Two story lines are currently under development: one related to the use of drugs other than alcohol, and one related to concurrent disorders.

Youth Net

http://www.youthnet.on.ca

Youth Net/Réseau Ado is a mental health program run by youth for youth. The goal is to involve as many people as possible between the ages of 13 and 20 in the promotion of youth mental health. As well, the program helps people identify early signs of mental illness so that they can take the next step to get help.

Youth Net also produces Youth Fax, a monthly newsletter, written for youth by youth. It deals with issues affecting all youth: stress, relationships, independence, jobs, etc. Youth Fax is put

together by a youth editor, with contributions from youth all over the region. We are always looking for contributions of art, poetry, stories, opinions, questions, so send them in!!!

Because youth have asked us to, we are also starting to provide ongoing support groups led by young facilitators for depression, self-esteem, or an issue, which you suggest, in communities around the region. If you have any questions or comments about Youth Net/Réseau Ado or would like to get involved with the program, please refer to the Web site.

Please note: Aside from our own sites, no endorsement of any of the above sites by the Centre for Addiction and Mental Health should be inferred.

APPENDIX D: TOLL-FREE PHONE LINES — DISTRESS LINES

Distress lines are an anonymous way to get help during a crisis. They also provide information on getting long-term help for the caller, a family member or a friend. They are accessible 24 hours a day. If in doubt about where to call in an emergency, call 911.

DIRECT (Depression Information Resource and Education Centre Toll-free)

Public Line: 1-888-557-5050, ext. 8000

Physician Line: 1-888-557-5050, ext. 800

These toll-free phone lines provide comprehensive information on mood and anxiety disorders through pre-recorded messages, which are available 24 hours a day. The information available through DIRECT has been written and reviewed by members of the internationally recognized Mood Disorders Program, part of the Faculty of Health Sciences at McMaster University.

Kid's Help Phone

1-800-668-6868

Kids Help Phone is Canada's only toll-free, 24 hour, national bilingual telephone counselling service for children and youth. Provides counselling services directly to children and youth between the ages of 4 and 19 years and helps adults aged twenty and over find the counselling services they need.

Parents, teachers, and any other concerned adults are welcome to call for information and referral services at any time.

Distress Centres of Ontario

http://www.dcontario.org/members.html

Please refer to the DCO Web site to find the number of the Distress Centre member in or near your community.

Crisis Centres in Ontario

http://www.siec.ca/siec/provinces/ontario.htm

Provides numbers and contact information for a large number of crisis lines throughout Ontario.

Please note: Aside from our own sites, no endorsement of any of the above sites by the Centre for Addiction and Mental Health should be inferred.

APPENDIX E: ONTARIO MENTAL HEALTH ORGANIZATIONS

Centre for Addiction and Mental Health

Infoline: 1-800-463- 6273
or in Metro Toronto: (416) 595-6111

33 Russell St.
Toronto ON M5S 2S1
Web site: http://www.camh.net

Canadian Mental Health Association, Ontario Division

180 Dundas St. W. Suite 2301
Toronto ON M5G 1Z8

Phone: 416-977-5580
Fax: 416-977-2264 or 416-977-2813
E-mail: division@ontario.cmha.ca
Web site: http://www.ontario.cmha.ca

For information about the CMHA branch in your area, please call 416-977-5580, or visit the CMHA National Web site at http://www.cmha.ca/

The Mood Disorders Association of Ontario and Toronto

40 Orchard View Blvd., Suite 222
Toronto ON M4R 1B9

Phone: 416-486-8046
Toll-free: 1-888-486-8236
Fax: 416-486-8127
E-mail: mdamt@sympatico.ca
Web site: http://www3.sympatico.ca/mdamt/

For information about groups in your area, please call 1-888-486-8046.

Schizophrenia Society of Ontario

885 Don Mills Rd., Suite 322
Don Mills ON M3C 1V9

Phone: 416-449-6830
Toll-free: 1-800-449-6367
Fax: 416-449-8434
E-mail: sso@web.net
Web site: http://www.schizophrenia.on.ca/

For information about the chapter in your area, please call 1-800-449-6367, or visit the SSO Web site.

The Self-Help Resource Centre

40 Orchard View Blvd., Suite 219
Toronto ON M4R 1B9

Phone: 416-487-4355 (in Toronto)
Toll-free: 1-888-283-8806 (outside Toronto)
Fax: 416-487-0344
E-mail: shrc@selfhelp.on.ca
Web site: http://www.selfhelp.on.ca/

Ontario Obsessive Compulsive Disorder Network

P.O. Box 151
Markham ON L3P 3J7

Tel: 416-410-4772
Fax: (905) 472-4473
E-mail: oocdn@interhop.net
Web site: http://www.oocdn.org

Please note: Aside from our own sites, no endorsement of any of the above sites by the Centre for Addiction and Mental Health should be inferred.

APPENDIX F: SUGGESTED AUDIOVISUAL RESOURCES

DOCUMENTARIES

From the National Film Board of Canada, Sales and Customer Services, D-10
PO Box 6100, Station Centre-Ville
Montreal, Quebec H3C 3H5 www.nfb.ca

available by calling toll-free: 1-800-267-7710
Fax: (514)283-7564

(Most titles $39.95 each)

A Gift for Kate **(National Film Board, 28 minutes, 1986)**
Kate is a recently discharged psychiatric patient who now lives in a run-down halfway house. The weekly visits from her 15-year-old son, Arthur, are bright spots in her difficult life. For Arthur, who has trouble dealing with his mother's condition, the visits are difficult. Arthur's embarrassment and confusion lead him to lie to his girlfriend about Kate, with some surprising results when the two women meet.

***Beautiful Dreamers* (National Film Board, 105 minutes, 1989)**

The superintendent of the London insane asylum, Dr. Maurice Bucke, despairs of the treatment methods in use during the Victorian era, which consist essentially of restraint and electroshock. At a conference in Philadelphia, he meets the American poet Walt Whitman, who has avant-garde ideas about mental illness, sexuality, the emotions and life in general. Bucke invites Whitman to London, with profound results.

***Conspiracy of Silence* (National Film Board, 26 minutes, 1981)**

A dramatic film about generational differences that almost split a family apart. Anna's parents don't trust her. Jack, her brother, committed suicide a year ago. Her parents disguised it as a car accident. Tension builds between Anna and her parents until she attempts suicide. The magnitude of their problems prompts a family reconciliation. Dramatic, realistic, fast-moving, this film sounds an alarm on the subject of teenage suicide.

***First Break* (National Film Board, 51 minutes, 1997)**

Three per cent of Canadians will experience a psychotic episode at some point during their lives. This video explores the different outcomes of a first episode of mental illness on three young adults and their families. Shot over a year, this video dispels the myths and questions the stigma associated with mental illness, while providing a powerful portrait of coping.

***The Myths of Mental Illness* (National Film Board, 56 minutes, 1988)**

Under mounting pressure at work and in his personal life, a successful journalist "burns out." *The Myths of Mental Illness* tells the story of his breakdown and traces his battle to regain his life's meaning. Interviews with prominent psychiatrists who hold opposing views of mental illness are intercut with the powerful drama.

The film raises questions about coping with stressful life and work situations, mental health and illness, psychiatry, drug therapy and psychotherapy, the healing power of human relationships, human freedom and dignity, technology and the invasion of privacy, and media integrity.

***Remembering Tom* (National Film Board, 24 minutes, 1999)**

Tom was 18 when he killed himself, leaving his family to deal with the anguish of his death. We meet Tom's parents, sister and brother two years later. They convey how they have learned to live with, not "get over" Tom's suicide. Rachel, 17, describes how she coped with the "greatest pain anyone could imagine" and recounts overcoming her own suicidal thoughts in the months after her brother died. The strength and resilience of Rachel and her family vividly demonstrate that, although we cannot always prevent such a tragedy, we can make choices about how to cope.

***Shattered Dreams* (National Film Board, 28 minutes, 1989)**

Shattered Dreams is a powerful and emotional exploration of the experiences of a family forced to deal with the tragedy of schizophrenia in a loved one — not once, but twice. The Martini family lived through the turmoil of losing their youngest son Ben to schizophrenia and eventually suicide, only to discover six years later that a second son, Liv, has developed the disease. Clem Martini, a third brother, narrates the film, sharing with us his family's journey through a world of confusion, guilt, loss, and ultimately, hope.

***Someone To Talk To* (National Film Board, 27 minutes, 1996)**

In over 6,000 Canadian Schools, peer helping programs have successfully trained kids to help each other overcome everything from nagging personal problems to full-blown crises. In the process, peer helpers learn about empathy and improve their own social skills. This eye-opening portrait follows a group of volunteers from two secondary schools.

***The Sterilization of Leilani Muir* (National Film Board, 47 minutes, 1996)**

A single IQ test and misguided "science" irreparably changed the life of a 14-year-old Canadian girl. This powerful documentary follows Leilani Muir's search for justice and explores how eugenics (improving hereditary qualities of a race through the control of reproduction) became acceptable in the early 1900s.

***Thin Dreams* (National Film Board, 20 minutes, 1986)**

A film made by young women participating in a training program sponsored by the Secretary of State's International Youth Secretariat and Studio D of the National Film Board. The film is a look at how young women in secondary school feel about their bodies, and how their self-images are affected by North American society's obsession with thinness.

***Working Like Crazy* (National Film Board, 54 minutes, 1999)**

Laurie spent years in psychiatric isolation and now runs a courier business. Diana has transformed rage and family violence into work for the Ontario Council of Alternative Businesses. Meet these and other former mental health patients who work in businesses owned and run by other psychiatric survivors. Labelled "unemployable," they are now earning an income and rebuilding their lives. *Working Like Crazy* is about alternatives to conventional community mental health and economic development. It portrays work as a human process that rebuilds people's connections to one another.

FEATURE FILMS

There are also a number of feature films that address issues of mental illness that may be appropriate for classroom use. These videos are most likely available in your local video store.

I Never Promised You a Rose Garden (Anthony Page, 1977) AA

Ordinary People (Robert Redford, 1980) AA

Permanent Record (Marisa Silver, 1988) AA

Sybil (Daniel Petrie, 1976) AA

APPENDIX G: ADDITIONAL PROGRAMS AND RESOURCES

Substance use

UNDER THE INFLUENCE? EDUCATOR'S KIT ON ALCOHOL ADVERTISING FOR STUDENTS IN GRADE 7-10.

ARAPO (Association to Reduce Alcohol Promotion in Ontario) 1999.
Lesson plans, presentation outline and activities focusing on media literacy and alcohol advertising for youth. Contact: Kari Sutoski, ARAPO co-ordinator, 750 Oakdale Rd. Unit 60, Toronto. M3N 2Z4

(416) 740-9592.

EDUCATING STUDENTS ABOUT DRUG USE AND ABUSE — READY-TO-USE LESSON PLANS FOR DRUG EDUCATION IN YOUR CLASSROOM.
Centre for Addiction and Mental Health.
A curriculum support for the Ontario Curriculum, Grades 1-8. Identifies progression and expectation for Grades 1 to 8. Available free from the Web site: http://sano.camh.net/curriculum.htm

Opening Doors: A Personal and Social Skills Program.
Centre for Addiction and Mental Health. 1995.
A program for secondary school "at-risk" students that addresses life skills in an interactive and challenging series of activities. Call 1-800-661-1111 for details about accessing the program. Available in French.

About Alcohol, About Cocaine, About Marijuana, About Smoking.
Centre for Addiction and Mental Health.
Written and illustrated in the style of a comic book, these four booklets use humour to deliver a serious message to teens. They describe the sensations and dangers associated with each substance, legal penalties for possession and trafficking, health concerns and a brief history of the drug. To order class sets, contact the Centre for Addiction and Mental Health at 1-800-661-1111.

Virtual Party: www.virtual-party.org
The Virtual Party is an interactive, educational Internet-based resource simulating a party situation, providing information to youth about alcohol emphasizing healthy choices and imparting skills for the reduction of harm. It is targeted at youth between the ages of 13 and 19. The young person is able to choose either a male or female character, and make choices about their activities during a "virtual" event. Two story lines are currently under development: one related to the use of drugs other than alcohol, and one related to concurrent disorders.

Your Life: Your Choice! An educational resource for teaching young teens about alcohol: www.schoolnet.ca/alcohol
The goal of this site is to improve the quality and breadth of alcohol abuse prevention education in Canadian schools. More specifically, it contains educational resource materials that support the acquisition of information and the development of skills and attitudes on the use, misuse and abuse of alcohol.

Suicide prevention

asist (Applied Suicide Intervention Skills Training) is a two-day workshop designed for anyone who may come in contact with a person at risk of suicide. This world-wide suicide prevention program was developed by LivingWorks, a public service corporation out of Calgary Alberta, and is appropriate for mental health professionals, volunteers working in the community, physicians, nurses, police, teachers, counsellors, clergy and youth workers. To learn more about this training opportunity and how to gain access to it, contact your local branch of the Canadian Mental Health Association. A list of local branches of the CMHA can be found on their Ontario Web site < www.ontario.cmha.ca > or by calling their toll-free line 1-800-875-6213.

Suicide Awareness Voices of Education: http://www.save.org/

Suicide Education and Information Centre: http://www.siec.ca/

Youthwork Links — Emotions and Behaviour — Suicide:
http://www.youthwork.com/healthmentsuicide.html

A Handbook for the Caregiver on Suicide Prevention
This handbook is intended for teachers, guidance counsellors, social workers, nurses and others working in the field of suicide prevention. Originally published by the Board of Education for the City of Hamilton on behalf of the Council on Suicide Prevention Hamilton and District in 1987, the handbook is currently in the process of being updated and is expected to be available in Spring 2001. For further information on this resource, contact:

Suicide Crisis Line
340 York Blvd.
Hamilton, ON L8R 3L2

Tel: (905) 521-1660
Fax: (905) 521-0244

Eating disorders

Ontario Community Outreach Program for Eating Disorders
(Toronto General Hospital and Hospital for Sick Children)

Dr. Gail McVey, Director
Tel: (416) 340-4051
Fax: (416) 340-4144
E-mail: gail.mcvey@sickkids.on.ca

Go Girls! Media Literacy, Activism and Advocacy Project
Go Girls (Giving Our Girls Inspiration and Resources for Lasting Self Esteem) is a program developed by Eating Disorders Awareness and Prevention, Inc. (EDAP). Its goal is to prevent the development of eating disorders among high school students through media literacy education, media activism and media advocacy. For more information please contact EDAP's Web site: www.edap.org

Please note: Aside from our own sites, no endorsement of any of the above sites by the Centre for Addiction and Mental Health should be inferred.

APPENDIX H: OVERHEADS AND HANDOUTS

WHAT IS STIGMA?

The following are definitions of "stigma" taken from different sources and from different historical periods:

"A mark or sign of disgrace or discredit."

"A visible sign or characteristic of a disease."

— *The Concise Oxford Dictionary, 1990*

"An attribute which is deeply discrediting"

— *Goffman, E., Stigma: The management of spoiled identity, 1963*

"A distinguishing mark or characteristic of a bad or objectionable kind; a sign of some specific disorder, as hysteria."

"A mark made upon the skin by burning with a hot iron, as a token of infamy or subjection; a brand."

"A mark of disgrace or infamy; a sign of severe censure or condemnation, regarded as impressed on a person or thing."

— *The Shorter Oxford English Dictionary*

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TERMS RELATED TO STIGMA

stereotype

"a person or thing that conforms to an unjustifiably fixed impression or attitude"

prejudice

"a preconceived opinion"

discrimination

"unfavourable treatment based on prejudice"

— *The Concise Oxford Dictionary, 1990*

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CASE STUDY

FRANK JONES

Frank Jones had been released from a provincial psychiatric hospital after having been admitted recently for intense psychotic symptoms. At the time of admission, Frank was highly agitated, yelling that the police were going to harm him because he's the Boston Strangler's brother. In the emergency room, Frank told the on-call psychiatrist that he was hearing voices of the devil preaching about his murderous relatives.

This was the patient's third hospitalization since schizophrenia was first diagnosed 12 years earlier at age 22. Frank had made an excellent recovery from previous hospital stays: He had been working as a salesman at a hardware store for the past six years, and lived nearby in a small but comfortable apartment. He visited a psychiatrist at the community mental health centre for medication about once a month. He also met with a counsellor there to discuss strategies to cope with his mental illness. Frank had several friends in the area and was fond of playing softball with them in park district leagues. He had been dating a woman in the group for about a year and reported that he was "getting serious." Frank was also active in the local Baptist Church, where he was co-leading Bible classes with the pastor. The reappearance of symptoms derailed his job, his apartment and his social life.

Recuperating from this episode involved more than just dealing with the symptoms of his illness. The reaction of friends, family members and professionals also affected what happened to Frank. The hardware store owner was frightened by Frank's "mental hospitalization." The owner had heard mentally ill people could be violent, and worried that the stress of the job might lead to a dangerous outburst in the shop. Frank's mother had other concerns. She worried the

demands of living alone were excessive: "He's pushing himself much too hard trying to keep that apartment clean and do all his own cooking," she thought. She feared Frank might abandon his apartment and move to the streets, just like other mentally ill people she had seen.

Frank's doctor was concerned his hospitalization signaled an overall lack of stability. His doctor believed schizophrenia was a progressively degenerative disease, a view first promoted by a renowned psychiatrist in 1913. In this view, psychiatric hospitalizations indicated the disease was worsening. The doctor concluded Frank's ability to live independently would soon diminish; it was better to prepare for it now rather than wait for the inevitable loss of independent functioning. So the doctor, with the help of Frank's mother and boss, talked him into leaving his job, giving up his apartment and moving in with his mother. Frank's mother lived across town, so he stopped attending the Baptist church. Frank was unable to meet with his friends and soon dropped out of the sports league. He stopped seeing his girlfriend. In one month, he lost his job, apartment and friends.

ALICE JOHNSON

Like Frank Jones, Alice Johnson had been diagnosed with a significant and chronic disease: diabetes. She had to carefully monitor her sugar intake and self-administer insulin each day. She watched her lifestyle closely for situations that might aggravate her condition. Alice also met regularly with a physician and a dietitian to discuss blood sugar, diet and exercise. Despite these cautions, Alice had an active life. She was a 34-year-old clerk-typist for a small insurance broker. She belonged to a folk-dancing club she attended at a nearby secondary school. She was engaged to an accountant at the insurance company.

Despite carefully watching her illness, Alice suffered a few setbacks, the last occurring about a month ago when she required a three-day hospitalization to adjust her medication. The doctor recommended a two-week break from

work after her discharge, and referred her to the dietitian to discuss appropriate changes in lifestyle. Even though diabetes is a life-threatening disease (in her most recent episode, Alice was near coma when she was wheeled into the hospital), no one suggested she consider institutional care where professionals could monitor her blood sugar and intervene when needed. Nor did anyone recommend Alice give up her job to avoid work-related stressors that might throw off her blood sugar.

Case studies adapted from Corrigan, P. (1998). The Impact of Stigma on Severe Mental Illness. Cognitive and Behavioral Practice, 5, *201-222.*

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FAMOUS PEOPLE WITH MENTAL ILLNESS

(Diagnosis or believed diagnosis of mood disorder, unless otherwise indicated)

ACTORS/ENTERTAINERS/DIRECTORS

Marlon Brando

Drew Carey

Jim Carrey

Dick Clark

John Cleese

Rodney Dangerfield

Richard Dreyfuss

Patty Duke

Frances Ford Coppola

Audrey Hepburn

Anthony Hopkins

Ashley Judd

Margot Kidder

Vivien Leigh

Joan Rivers

Roseanne

Winona Ryder

Charles Schultz

Rod Steiger

Damon Wayans

Robin Williams

ARTISTS

Paul Gaugin

Vincent van Gogh

Michelangelo

Vaslov Nijinski (schizophrenia)

Georgia O'Keefe

Jackson Pollock

ATHLETES

Lionel Aldridge (schizophrenia)

Oksana Baiul

Dwight Gooden

Peter Harnisch

Greg Louganis

Elizabeth Manley

Jimmy Piersall

Monica Seles

Darryl Strawberry

Bert Yancey

AUTHORS/JOURNALISTS

Hans Christian Andersen

James Barrie

William Blake

Agatha Christie

Michael Crichton

Charles Dickens

Emily Dickinson

William Faulkner

F. Scott Fitzgerald

John Kenneth Galbraith

Ernest Hemingway

John Keats

Larry King

Eugene O'Neill

Sylvia Plath

Edgar Allen Poe

Mary Shelley

Neil Simon

William Styron

Leo Tolstoy

Mark Twain

Mike Wallace

Walt Whitman

Tennessee Williams

Virginia Woolf

BUSINESS LEADERS

Howard Hughes (depression & OCD)

J.P. Morgan

Ted Turner

SCIENTISTS

Charles Darwin

Sigmund Freud

Stephen Hawking

Sir Isaac Newton

COMPOSERS/MUSICIANS/SINGERS

Irving Berlin

Ludwig van Beethoven

Karen Carpenter (anorexia)

Ray Charles

Frederic Chopin

Eric Clapton

Kurt Cobain

Leonard Cohen

Natalie Cole

Sheryl Crow

John Denver

Stephen Foster

Peter Gabriel

Janet Jackson

Billy Joel

Elton John

Sarah McLachlan

Charles Mingus

Alanis Morissette

Marie Osmond

Charles Parker

Cole Porter

Bonnie Raitt

Axl Rose

Robert Schumann

Paul Simon

James Taylor

Peter Tchaikovshy

POLITICAL FIGURES/WORLD LEADERS

Alexander the Great

Napoleon Bonaparte

Barbara Bush

Winston Churchill

Diana, Princess of Wales

Tipper Gore

Thomas Jefferson

Ralph Nader

Florence Nightingale

George Patton

George Stephanopolous

(Taken from the Mood Disorders Web site: www.ndmda.org)

FACT OR FICTION?

1. One person in 100 develops schizophrenia. True or False
2. A person who has one or two parents with mental illness is more likely to develop mental illness. True or False
3. Mental illness is contagious. True or False
4. Mental illness tends to begin during adolescence. True or False
5. Poor parenting causes schizophrenia. True or False
6. Drug use causes mental illness. True or False
7. Mental illness can be cured with willpower. True or False
8. People with mental illness never get better. True or False
9. People with mental illness tend to be violent. True or False
10. All homeless people are mentally ill. True or False
11. Developmental disabilities are a form of mental illness. True or False
12. People who are poor are more likely to have mental illness than people who are not. True or False

MENTAL HEALTH STATISTICS FOR ONTARIO

- 22 per cent of Ontarians have experienced at least one mental health problem in their lifetime.
- Women are more likely than men to experience a mental health problem, specifically anxiety or depression.
- Men are more likely to experience antisocial personality disorder
- 31 per cent of 15- to 24-year olds have experienced a mental health problem:
- 27 per cent have anxiety problems
- 7.5 per cent have affective problems
- 15- to 24-year-olds are more likely to have social phobias and bipolar disorder.
- Older people experience depression more often than younger people.
- Mental disorders (especially depression) are more common among people who are separated, divorced or widowed.
- 52 per cent of Ontarians whose parents have experienced a mental health problem also experience a mental disorder.

Source: Canadian Mental Health Association, Ontario Division, 1999

For further information, please refer the source document of these statistics.

It can be found on the Canadian Mental Health Association, Ontario Division's Web site:

http://www.ontario.cmha.ca/mhic/omhss_v1.pdf

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DEFINITION OF MENTAL ILLNESS

Mental illness is a disturbance in thoughts and emotions that decreases a person's capacity to cope with the challenges of everyday life.

DESCRIPTIONS OF MENTAL ILLNESSES — MOOD DISORDERS

Mood disorders are persistent changes in mood caused by biochemical imbalances in the brain. Major depressive disorder and bipolar disorder are two types of mood disorders.

Major depressive disorder is depressed mood accompanied by symptoms such as: loss of interest or pleasure in life; irritability; sadness; difficulty sleeping or sleeping too much; decreased or increased appetite; lack of concentration; sense of worthlessness; guilt; and in some cases, thoughts of suicide.

Bipolar disorder is a cycle of depressed mood, "normal" mood and mania. Mania is an elevated, exaggerated mood accompanied by symptoms such as: inflated self-esteem or confidence; a decreased need for sleep; increased energy; increased sexual drive; poor judgment; increased spending; agitation; non-stop talk; and increased involvement in pleasurable and possibly dangerous activities.

DESCRIPTIONS OF MENTAL ILLNESSES — PSYCHOSIS

Psychosis is the active state of experiencing hallucinations or delusions and can be organic (mental illness) or drug-induced.

Schizophrenia is a disturbance involving delusions, hallucinations, disorganized speech and/or disorganized or catatonic behaviour. Delusions are false beliefs or misinterpretations of situations and experiences. Hallucinations can be auditory, visual, olfactory (smell), gustatory (taste) or tactile (touch), but auditory hallucinations are most common. Schizophrenia is also associated with a deterioration of a person's ability to function at work, school and/or socially.

DESCRIPTIONS OF MENTAL ILLNESSES — ANXIETY DISORDERS

Anxiety disorders are associated with feelings of anxiousness, combined with physiological symptoms that interfere with everyday activities. Obsessive-compulsive disorder, phobias and post-traumatic stress disorder are types of anxiety disorders.

Obsessive-compulsive disorder is marked by repeated obsessions and/or compulsions that are so severe they interfere with everyday activities. Obsessions are disturbing, intrusive thoughts, ideas, or images that cause marked anxiety or distress. Compulsions are repeated behaviours or mental acts intended to reduce anxiety.

Post-traumatic stress disorder is the re-experiencing of a very traumatic event, accompanied by feelings of extreme anxiety, increased excitability and the desire to avoid stimuli associated with the trauma. The trauma could be related to such incidents as military combat, sexual assault, physical attack, robbery, car accident or natural disaster.

Phobias are significant and persistent fears of objects or situations. Exposure to the object or situation causes extreme anxiety and interferes with everyday activities or social life. Specific phobias have to do with objects or situations — for example, germs or heights. Social phobias have to do with social situations or performance situations where embarrassment may occur — for example, public speaking or dating.

DESCRIPTIONS OF MENTAL ILLNESSES — PERSONALITY DISORDERS

A personality disorder is a pattern of inner experience and behaviour that is significantly different from the individual's culture; is pervasive and inflexible; is stable over time; and leads to distress or impairment. Personality disorders usually begin in adolescence or early adulthood.

Dissociative identity disorder, formerly known as "multiple personality disorder," is the presence of two or more distinct identities that alternately control a person's behaviour. It reflects a failure to make connections between identity, memory and consciousness. Known by the general public as "split personality," there is now a controversy as to whether or not it is a real diagnosis.

DESCRIPTIONS OF MENTAL ILLNESSES — EATING DISORDERS

Eating disorders are a range of conditions involving an obsession with food, weight and appearance that negatively affect a person's health, relationships and daily life. Stressful life situations, poor coping skills, socio-cultural factors regarding weight and appearance, genetics, trauma, and family dynamics are thought to play a role in the development of eating disorders.

Anorexia Nervosa is characterized by an intense and irrational fear of body fat and weight gain, the strong determination to become thinner and thinner, the refusal to maintain a normal weight (for height and age) and a distorted body image.

Bulimia Nervosa is characterized by self-defeating cycles of binge eating and purging. Bingeing is the consumption of large amounts of food in a rapid, automatic and helpless fashion and leads to physical discomfort and anxiety about weight gain. Purging follows bingeing and can involve induced vomiting, restrictive dieting, excessive exercising or use of laxatives and diuretics.

(Eating Disorders Awareness and Prevention Web site: http://www.edap.org)

FACTORS THAT MAY CONTRIBUTE TO THE DEVELOPMENT OF MENTAL ILLNESS

The following are factors that may contribute to the development of mental illness:

- chemical imbalance
- substance abuse
- traumatic life events
- heredity
- other illnesses.

TREATMENT OF MENTAL ILLNESS

Biological treatments

- medication
- electroconvulsive therapy (ECT).

Psychosocial Interventions

- psychotherapy
- self-help groups
- family support and involvement
- community supports.

"VOICES" SCRIPT

VOICE 1

You jerk!
Stupid!
Everyone knows it

They're all looking at you
They know you're stupid

They are laughing at you
You're ugly
Hide your face
Run away

You're no good
You lazy, good for nothing

Get a job you bum
Do something
Don't listen to them

Go for a coffee
Have a cigarette
This is boring

Hurt yourself
You deserve it
You're useless
No one cares

VOICE 2

Save these people
They're devils
They must be persecuted

God works through you
You can save the world
You are Jesus, son of God

Cleanse yourself
Save the world
Dirty! Dirty!

Take your clothes off
Purify yourself
Go naked in the presence of God
Naughty! Naughty!

You're tired
Get out of here
Go to sleep

They're staring with evil eyes
Run away

Hit them now
Hit! Hit!
Before they hurt you

SUPPORT STRATEGIES

Here are some strategies for supporting someone with a mental health problem:

- Be supportive and understanding.
- Spend time with the person. Listen to him or her.
- Never underestimate the person's abilities.
- Encourage the person to follow his or her treatment plan and seek out support services.
- Become informed about mental illness.
- If you are a close friend or family member of someone who has a mental illness, make sure you get support as well. Crisis training, self-help and/or individual counselling will help you become a better support person.
- Put the person's life before your friendship. If you think the person needs help, especially if she or he mentions having thoughts of suicide, don't keep it a secret (even if the person may have asked you to). Tell his or her parents or someone else who can help.

Talking about Mental Illness

STUDENT EVALUATION — PRE-TEST

Today's Date: _____ School: _____

Teacher's Name: _____ Subject: _____

Female ☐ or Male ☐ Birth date: Day _____ Month _____ Year _____ Grade: _____

A. Please indicate how much you feel you **KNOW** about each of the following. Circle the number that best describes your knowledge.

	None	A little	Some	A lot
1. mental illness in general	1	2	3	4
2. how people cope with mental illness	1	2	3	4
3. different approaches to help persons with mental illness	1	2	3	4
4. what it is like to have a mental illness	1	2	3	4
5. what it is like to have a family member with mental illness	1	2	3	4
6. the causes of different forms of mental illness	1	2	3	4
7. how to recognize signs of mental illness	1	2	3	4
8. different training and career paths mental health workers have	1	2	3	4

B. Please indicate how much you agree or disagree with the following statements by circling the appropriate number.

	Strongly disagree	Disagree	Agree	Strongly agree
1. Most people with a serious mental illness can, with treatment, get well and return to productive lives.	1	2	3	4
2. In most cases, keeping up a normal life in the community helps a person with mental illness get better.	1	2	3	4

	Strongly disagree	Disagree	Agree	Strongly agree
3. People with mental illness are far less of a danger than most people believe.	1	2	3	4
4. Locating a group home or apartments for people with mental illness in residential neighbourhoods does not endanger local residents.	1	2	3	4
5. Locating a group home or apartments for people with mental illness in a residential area will not lower the value of surrounding homes.	1	2	3	4
6. People with mental illness are, by far, more dangerous than the general population.	1	2	3	4
7. Mental health facilities should be kept out of residential neighbourhoods.	1	2	3	4
8. Even if they seem OK, people with mental illness always have the potential to commit violent acts.	1	2	3	4
9. It is easy to recognize someone who once had a serious mental illness.	1	2	3	4
10. The best way to handle people with mental illness is to keep them behind locked doors.	1	2	3	4

THANK YOU

STUDENT EVALUATION — POST-TEST

Today's Date: _____ School: _____

Teacher's Name: _____ Subject: _____

Female ☐ or Male ☐ Birth date: Day ____ Month ____ Year ____ Grade: ____

A. Please indicate how much you feel you **KNOW** about each of the following. Circle the number that best describes your knowledge.

	None	A little	Some	A lot
1. mental illness in general	1	2	3	4
2. how people cope with mental illness	1	2	3	4
3. different approaches to help persons with mental illness	1	2	3	4
4. what it is like to have a mental illness	1	2	3	4
5. what it is like to have a family member with mental illness	1	2	3	4
6. the causes of different forms of mental illness	1	2	3	4
7. how to recognize signs of mental illness	1	2	3	4
8. different training and career paths mental health workers have	1	2	3	4

B. Please indicate how much you agree or disagree with the following statements by circling the appropriate number.

	Strongly disagree	Disagree	Agree	Strongly agree
1. Most people with a serious mental illness can, with treatment, get well and return to productive lives.	1	2	3	4
2. In most cases, keeping up a normal life in the community helps a person with mental illness get better.	1	2	3	4

	Strongly disagree	Disagree	Agree	Strongly agree
3. People with mental illness are far less of a danger than most people believe.	1	2	3	4
4. Locating a group home or apartments for people with mental illness in residential neighbourhoods does not endanger local residents.	1	2	3	4
5. Locating a group home or apartments for people with mental illness in a residential area will not lower the value of surrounding homes.	1	2	3	4
6. People with mental illness are, by far, more dangerous than the general population.	1	2	3	4
7. Mental health facilities should be kept out of residential neighbourhoods.	1	2	3	4
8. Even if they seem OK, people with mental illness always have the potential to commit violent acts.	1	2	3	4
9. It is easy to recognize someone who once had a serious mental illness.	1	2	3	4
10. The best way to handle people with mental illness is to keep them behind locked doors.	1	2	3	4

C. As a result of participating in the program, please indicate how much you agree or disagree with the following statements.

	Strongly disagree	Disagree	Agree	Strongly agree
1. The classroom activities and presentations held my attention.	1	2	3	4
2. I learned a lot from the presentations.	1	2	3	4
3. The presentations are a good way to learn about mental illness.	1	2	3	4
4. It is valuable for students to be able to ask presenters questions.	1	2	3	4

	Strongly disagree	Disagree	Agree	Strongly agree
5. The experience of the presenters was relevant to people my age.	1	2	3	4
6. I learned some new information about mental illness.	1	2	3	4
7. I feel better about my ability to talk with someone with mental illness.	1	2	3	4
8. I feel that I know more about the emotions experienced by someone who has a mental illness.	1	2	3	4
9. In the future, I will feel more comfortable when I meet people with mental illness.	1	2	3	4
10. I would recommend this program to a friend who hasn't participated in it.	1	2	3	4

D.

1. What I liked MOST about the program was:

_____

_____

_____

2. What I liked LEAST about the program was:

_____

_____

_____

3. If you have any further comments on the program or would like to make suggestions for the improvement of the program, please add them below.

_____

_____

_____

_____

THANK YOU

Talking about Mental Illness

TEACHER EVALUATION

We would appreciate your help in evaluating the Talking About Mental Illness program. Your feedback will help us to improve it for the future.

Today's Date: _____ Grade: _____

School: _____ Name: _____

Date of Program: _____

1. (a) Please name the students' courses that the Talking About Mental Illness Program is being incorporated into:

   _____

   (b) Approximately how much time was devoted to the suggested classroom activities **PRIOR TO** the presentation?

   _____ hours

   (c) Approximately how much time did you spend **AFTER** the presentation debriefing?

   _____ hours

   Please describe:

   _____

2. How helpful did you find the classroom activities contained in the Teachers Resource?

   Not at all helpful 1 2 3 4 5 Very helpful

   Please list which activities you used:

   _____

3. In your experience, how closely did the suggested classroom activities compliment the curriculum guidelines for your course?

   Not at all helpful 1 2 3 4 5 Very helpful

4. (a) What did you hope your students would learn from participating in the program?

_____

_____

(b) To what extent were your expectations satisfied?

Not at all 1 2 3 4 5 To a great extent

_____

_____

5. Do you feel the choice of presenters (e.g., consumers, family) was appropriate?

Yes ☐ No ☐

Please comment:

_____

_____

6. Do you feel that the classroom setting was appropriate for the presentation?

Yes ☐ No ☐

Please explain:

_____

_____

7. Please make comments and suggestions on the presentation you attended (i.e., length, depth, format, content, etc.).

_____

_____

_____

_____

8. What other tools or activities would you like to see included in the *Teacher's Resource*?

_____

_____

_____

9. Overall, how would you rate the program?

1	2	3	4	5
EXCELLENT	VERY GOOD	GOOD	SATISFACTORY	UNSATISFACTORY

10. Any additional comments or suggestions?

THANK YOU

For information on other Centre for Addiction and Mental Health resource materials or to place an order, please contact:

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Centre for Addiction and Mental Health
33 Russell Street
Toronto, ON M5S 2S1
Canada
Tel.: 1-800-661-1111 or
416-595-6059 in Toronto
E-mail: marketing@camh.net

Web site: www.camh.net

Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

Addiction Research Foundation
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